STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065169	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Pueblo	1601 Constitution Rd Pueblo, CO 81001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to ensure resident rights were promoted and dignity was maintained for one (#25) of two residents out of 46 sample residents. Specifically, the facility failed to ensure Resident #25 was provided with incontinence supplies. Findings include: I. Facility policy The Promoting/Maintaining Resident Dignity policy, revised 1/2023, was provided by the nursing home administrator (NHA) on 7/18/24 at 5:16 p.m. It documented in pertinent part, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances residents quality of life by recognizing each residents' individuality. II. Resident #25 A. Resident status Resident #25, age 77, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included atrial fibrillation (abnormal heart rhythm), type two diabetes (high blood sugar) and muscle weakness. The 5/20/24 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 moderate assistance with transfers and could not ambulate. B. Resident interview (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was interviewed on 7/15/24 at 10:43 a.m. She said the facility got rid of the reusable incontinence pads a couple months ago. She said the staff put a folded bath blanket under her when she was lying in her bed. She said she sometimes had incontinent episodes and ended up saturated in urine because the bath mat did not absorb liquid. She said the bed would get completely covered in urine when she had a urinary incontinence episode. She said she felt frustrated by this and it upset her. C. Observations On 7/15/24 at 10:43 a.m. Resident #25's room was observed. There was a folded bath blanket over the fitted sheet in her bed. There was not an incontinence pad over the bath blanket. On 7/17/24 at 2:10 p.m. the [NAME] hall shower room. There were no reusable incontinence pads for residents on the linen cart. On 7/17/24 at 4:30 p.m. the central supply room was observed. There were no reusable or disposable incontinence pads in the room. III. Staff interviews The central supply director (CSD) was interviewed on 7/17/24 at 4:30 p.m. The CSD said the facility did not order the reusable incontinence pads anymore. She said the facility ordered the disposable pads only for residents with air mattresses or wounds. Certified nursing aide (CNA) #1 was interviewed on 7/17/24 at 2:10 p.m. CNA #1 said the facility stopped carrying the reusable incontinence pads a while ago. She said staff should check and change residents who were incontinent every two hours or as needed. She said the staff folded bath blankets and put them under some residents instead of the incontinence pads. CNA #1 said the facility had the disposable pads but they were only used for certain residents. CNA #1 said if a resident soiled their mattress she would change the sheets and wipe down the mattress with an incontinence wipe. She said she would only sanitize the mattress if the resident was out of the bed. The director of nursing (DON) was interviewed on 7/18/24 at 12:00 p.m. The DON said the facility had used reusable incontinence pads in the past, but no longer ordered the supply. She said the facility had stopped using them due to skin breakdown and infections. She said one resident had complained to her about no longer using the reusable incontinence pads and she educated the resident as to why the facility had gotten rid of them. She said she had not heard concerns regarding Resident #25. She said the facility used disposable pads only for residents with weeping wounds or air mattresses.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to ensure the self-administration of medication was clinically appropriate for one (#5) of one resident out of 46 sample residents. Specifically, the facility failed to ensure Resident #5 was assessed for safe self-administration of medications. Findings include: I. Facility policy and procedure The Resident Self-Administration of Medication policy and procedure, revised 2/2024, was provided by the nursing home administrator (NHA) on 7/18/24 at 5:16 p.m. It documented in pertinent part, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms. II. Resident #5 A. Resident status Resident #5, age 74, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included muscle weakness, hypertension (high blood pressure) and a history of falling. The 6/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She used a wheelchair and could ambulate around the facility with set-up assistance. B. Observations On 7/15/24 at 11:00 a.m. Resident #5 was in her room sleeping. There was a cup of medications on the bedside table with eight pills At 11:30 a.m. Resident #5 woke up and saw the cup of pills on her bedside table. She was observed self-administering the cup of pills. C. Record review According to the July 2024 CPO, Resident #5 was able to self-administer the following medications: Arformoterol nebulizer (inhaler) to be administered two times daily unsupervised self-administration, ordered on 5/1/23. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Albuterol Sulfate (inhaler) to be administered every four hours as needed for shortness of breath or wheezing unsupervised self-administration, ordered 5/1/23. -The July 2024 CPO did not reveal a physician's order for the resident to self administer any of her other prescribed medications. The 6/27/23 self-administration assessment documented Resident #5 was able to self-administer Arformoterol nebulizer, Atrovent nebulizer and budesonide nebulizer. -There was no documented assessment for self-administration of any of her other prescribed medications. -Resident #5's comprehensive care plan did not include Resident #5's self-administration of medications. D. Staff interviews Registered nurse (RN) #2 was interviewed on 7/15/24 at 11:40 a.m. RN #2 said Resident #5 was sleeping when she attempted to administer her medications (on 7/15/24) so she left the medications at the resident's bedside. RN #1 was interviewed on 7/17/24 at 4:15 p.m. RN #1 said Resident #5 had a physician's order for the self-administration of an inhaler and nebulizer medication. He said if the resident was able to self-administer medications it should be included in her care plan. RN #1 said Resident #5's self-administration assessment did not include any pill medications and she needed a self-administration of medication assessment completed in order to self-administer pill medications. He said there were residents with dementia who were ambulatory on the unit with Resident #5, so it was a risk to leave a cup of pills at the resident's bedside. The director of nursing (DON) was interviewed on 7/18/24 at 12:00 p.m. The DON said in order for a resident to be able to self-administer medications, a self-administration assessment should be completed by the nurse, a physician's order obtained, education provided by the nurse to the resident and it should be included on the resident's comprehensive care plan. The DON said there were residents with dementia that wandered who lived on the same unit as Resident #5. The DON said Resident #5 had physician's orders and assessments to self-administer inhaler medications and nebulizers. She said Resident #5 did not have a physician's order or a self-administration assessment for any pill medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to provide reasonable accommodation necessary to accommodate mobility and accessibility in the resident's environment for one (#289) of one resident reviewed out of 46 sample residents. Specifically, the facility failed to ensure Resident #289's bathroom call light was consistently accessible to him. Findings include: I. Resident #289 status Resident #289, age 74, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), chronic respiratory failure with hypoxia (low oxygen level) and chronic obstructive pulmonary disease (chronic lung disease that makes it hard to breathe and restricts air flow). According to the brief interview for mental status (BIMS) completed 7/11/24, the resident was cognitively intact with a score of 14 out of 15. He required substantial to maximum assistance of two staff members transferring from bed to chair, using the bathroom and turning in bed. According to the 7/13/24 functional assessment, Resident #289 required substantial to maximum assistance of two staff members transferring from bed to chair, using the bathroom and turning in bed. II. Resident interview and observations Resident #289 was interviewed on 7/16/24 at 11:15 a.m. Resident #289 said he had to yell, whistle or bang on the wall for help when he could not reach his call bell cord in the bathroom. He said last night (7/15/24) a staff person got upset with him for yelling, but he said he could not reach the call bell cord in the bathroom and he needed help. During the interview, Resident #289's call bell cord in the bathroom was observed to be wrapped around the grab bar on the right side of the toilet near the floor. Resident #289 said he could not reach his call bell when it was wrapped around the grab bar near the floor. He said his right arm was affected from his stroke and he did not have full range of motion. On 7/17/24 at 1:56 p.m. Resident #289's call bell cord in the bathroom was again observed to be wrapped around the grab bar on the right side of the toilet. The cord had fallen to the bottom of the grab bar. Resident #289 said it was difficult for him to reach his call bell cord with the limited range of motion in his right arm. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 10:30 a.m. Resident #289's call bell cord in the bathroom was observed tied to the top of the grab bar on the right side of the toilet. Resident #289 said he was better able to reach the call bell cord where it was placed on the top of the grab bar. III. Record review The baseline care plan, initiated 7/10/24, indicated Resident #289 was alert, oriented and able to follow instructions. The fall prevention intervention on the care plan indicated to keep the call light within reach at all times. The nurse practitioner visit note, dated 7/11/24, indicated the resident had a stroke with right hemiplegia (paralysis on one side of the body) and right upper extremity decreased range of motion. IV. Staff interview The director of nursing (DON) was interviewed on 7/18/24 at 2:54 p.m. The DON said call lights should be placed within the residents' reach. She said the certified nurse aides (CNA) should not leave residents in the bathroom, but instead, stand outside the bathroom door to give them privacy. She said the CNAs should always ensure the call light in the bathroom was within reach of the resident.

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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** 48114 Based on record review and interviews, the facility failed to take steps to prevent abuse for one (#23) of two residents reviewed for abuse out of 46 sample residents. Specifically, the facility failed to protect Resident #23 from sexual abuse by Resident #65. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised October 2022, was provided by the nursing home administrator (NHA) on 7/15/24 at 10:00 a.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment. The identification, ongoing assessment, care planning of appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. II. Incident of sexual abuse between Resident #23 and Resident #65 on 5/24/24 The facility investigation was provided by the NHA on 7/17/24 at 12:00 p.m. The investigation included a written statement from the certified nurse aide (CNA) #5 who witnessed the incident. It documented on 5/24/24, while walking down the hall, Resident #65 was seen holding Resident #23's head with his left hand while rubbing her chest and stomach with his right hand. Licensed practical nurse (LPN) #3 was immediately notified. LPN #3 was able to get Resident #65 to stop and Resident #23 was taken back to her room. -The written statement was not dated. On 5/30/24 interviews were conducted with four staff members and four residents. None of the staff members or the residents had any concerns regarding abuse. The investigation failed to document if Resident #23 was assessed following the incident. -The investigation failed to document whether the facility substantiated or unsubstantiated the sexual abuse. III. Resident #65 (assailant) A. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included unspecified dementia and traumatic brain injury. The 6/26/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15. He required supervision or touching assistance with showering and bathing . He was independent with all other activities of daily living (ADL). According to the MDS assessment, Resident #65 had no physical behavioral symptoms directed towards others. B. Record review The affections care plan, initiated on 7/4/24 (over one month after the incident with Resident #23), documented Resident #65's affections could be distressing to others at times. Interventions included educating staff and family members regarding the normalcy of affectionate behaviors, discussing any plans to divert behaviors, discouraging or monitoring displays of affection, encouraging open discussion about affections with the resident's family and staff team to clarify preferences for how to handle the situations, offering activity props, directing the resident toward tasks and change seating to discourage behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The personal space care plan, initiated on 5/24/24, documented Resident #65 tended to periodically invade the staff's personal space and could be verbally inappropriate with staff at times. Interventions included anticipating and meeting the resident's needs, providing the opportunity for positive interaction and attention, stopping and talking with the resident when passing by if reasonable, discussing the resident's behavior, explaining/reinforcing why behavior is inappropriate and/or unacceptable to the resident, intervening as necessary to protect the rights and safety of others, approaching and speaking in a calm manner, diverting the resident's attention, removing the resident from situation and taking to an alternate location as needed, offering reminders and cues as needed; redirecting the resident when needed, reminding the resident of healthy boundaries as needed and redirecting to another activity of choice. -Review of Resident #65's electronic medical record (EMR) revealed there were no progress notes related to the resident's sexual abuse incident with Resident #23 on 5/24/24. IV. Resident #23 (victim) A. Resident status Resident #23, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included cerebral palsy and quadriplegia. The 5/13/24 MDS assessment revealed the resident had severe cognitive impairments and was not able to make decisions regarding daily life through staff assessment She was dependent on staff for all ADLs. B. Record review The impaired cognition care plan, initiated on 11/14/23, documented Resident #23 exhibited both short and long term deficits and had difficulty making herself understood and understanding others. Interventions included encouraging the use of one or two word responses and simple phrases, giving verbal cues and reminders when she could not remember, phrasing questions to yes or no responses, allowing ample time to respond using simple words and sentences, and validating thoughts and feelings when confused or anxious. The communication care plan, initiated on 12/6/23, documented Resident #23 had a communication problem related to neurological symptoms. Resident #23 was able to answer yes and no questions. Interventions included anticipating and meeting the resident's needs, communication, allowing adequate time to respond, repeating words as necessary, requesting clarification from the resident to ensure understanding, facing the resident when speaking, making eye contact, turning off the television/radio to reduce environmental noise, asking yes or no questions if appropriate, using simple, brief, consistent words/cues, using alternative communication tools as needed; and monitoring/documenting residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. -Review of Resident #23's EMR revealed there were no progress note related to the incident with Resident #65 on 5/24/24. -Review of Resident #23's EMR did not document if Resident #23 was assessed following the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Staff interviews Registered nurse (RN) #3 was interviewed on 7/18/24 at 1:59 p.m. RN #3 said she had seen Resident #65 hovering over Resident #23 and getting too close prior to the 5/24/24 incident. She said Resident #23's representative told Resident #65 he was standing too close and to move away from Resident #23 on 5/23/24. She said she did not witness the incident where Resident #65 had touched Resident #23. RN #3 said she wrote a progress note about Resident #65 getting too close to Resident #23. She said that was the first time she had seen Resident #65 getting too close to another resident. She said when she witnessed any inappropriate behaviors she would write progress notes in the resident's EMR. RN #3 said she was not sure if Resident #65 was being monitored on one-to-one, or on safety fifteen-minute checks. She said both residents had always resided on separate hallways. She said Resident #65 walked all over the facility. She said she did not know if Resident #65 had any other sexually inappropriate behaviors towards others. CNA #5 was interviewed on 7/18/24 at 2:09 p.m. CNA #5 said she witnessed the inappropriate touching between Resident #65 towards Resident #23 on 5/24/24. She said the incident took place down the hallway where Resident #23 resided. She said Resident #65 had one hand over Resident #23's head and his other hand was rubbing Resident #23's chest. She said she told the nurse. She said the residents were separated. She said she took Resident #23 to her room and laid her down and the LPN asked Resident #65 to step away. She said Resident #65 argued with the LPN and said that Resident #23 had told him that she liked him. CNA #5 said Resident #65 was placed on a one-to-one caregiver for one to two weeks. She said she did not know if his care plan was updated. She said she was asked by the DON to write a statement on what she saw. CNA #5 said Resident #65 had a couple of occasions where he had gotten too close to Resident #23 before the inappropriate touching occurred. She said she had had to tell Resident #65 to walk away from Resident #23. -However, review of Resident #65's care plan did not indicate the resident had been placed on a one-to-one caregiver following the incident with Resident #23. CNA #5 said she had seen Resident #65 getting close to another female resident who also had cognitive issues. She said she had never seen Resident #65 touch anyone inappropriately. She said Resident #65 needed to be watched closely. The director of nursing (DON) was interviewed on 7/18/24 at 2:21 p.m. The DON said when she heard about the incident, an investigation was completed. She said she gathered witness statements from staff, residents and questionnaires with families. The DON said a progress note should have been documented in the EMR for both residents. She said the RN, or whomever the incident was reported to, should have written a progress note. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the interdisciplinary treatment team (IDT) met the following business day after the incident (5/27/25). She said any time there was an investigation, the IDT met. She said a progress note should have been written to document the IDT met. She said she was responsible for putting in the IDT notes for risk management regarding skin and falls and for inappropriate behaviors. She said the inappropriate behavior between Resident #65 and Resident #23 was her first incident since she had started working at the facility. She said, moving forward, she would make sure that an IDT note was completed. The DON said staff received education about abuse and reporting following the incident. She said the staff were monitoring both residents to ensure they were not sitting close to each other during meal times in the dining room. She said when Resident #23 was up she was by the nurses' station so the staff could keep a close eye on her. She said Resident #65 was placed on-a-one to one caregiver after the incident on 5/24/24. She said Resident #65 was placed on a one-to-one until the investigation was concluded. She said the one-to-one was removed following the investigation because the residents who were interviewed during the investigation did not report feeling unsafe around Resident #65. The DON said she knew Resident #65 had made inappropriate statements to the receptionist but not towards female residents. She said she did not know if this was a one time incident. She said when she had a conversation with Resident #65 about the incident, he said he just wanted to talk to Resident #23. The DON said a care plan should have been implemented for Resident #65's inappropriate behaviors immediately after the incident. She said she needed to fix the process moving forward. LPN #3 was interviewed on 7/18/24 at 2:56 p.m. LPN #3 said she was working when the incident between Resident #65 and Resident #23 happened. She said when she was notified of what had happened, she alerted the charge nurse. She said the charge nurse had contacted the DON and the NHA. She said when the incident happened, she and CNA #5 separated the two residents. LPN #3 said she was informed that Resident #65 was not allowed down Resident #23's hallway after the 5/24/24 incident. She said she was told by the DON that they could not keep Resident #65 from walking down Resident #23's hallway because it was his right. She said Resident #65 walked down Resident #23's hallway several times a day and tried to peek into her bedroom. She said she checked in on Resident #23 all the time. LPN #3 said she was not aware if Resident #65 had been sexually inappropriate towards any other female residents. LPN #3 said she was given a directive from her charge nurse (RN #3) to hold off on writing a progress note in the EMR because they were waiting on CNA #5 to write her statement. She said she would have written a progress note but, because she was given a directive not to, she did not. CNA #6 was interviewed on 7/18/24 at 3:19 p.m. CNA #6 said Resident #65 was allowed to walk wherever he wanted to because it was his right. She said the DON and the NHA told her that it was a residents' right that he could walk anywhere. She said there should be more interventions put into place to keep Resident #65 from coming down Resident #23's hallway. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #6 said when Resident #23 was out of her room, she would sit in her wheelchair by the nurse's station. She said when Resident #23 was in her room she made sure that her door was closed so Resident #65 could not go in. She said when she saw Resident #65 coming down the hallway she would get up right away and would watch him to make sure he did not do anything inappropriate. She said sometimes he would stop at Resident #23's door, especially when no one was watching. The NHA was interviewed on 7/18/24 at 4:43 p.m. The NHA said he neither substantiated or unsubstantiated the abuse at the end of the investigation. The NHA said he did not know that Resident #65 had actually touched Resident #23 inappropriately. He said he had two to three days to follow up on the incident. He said he had not wanted to label Resident #65 as a sexual perpetrator. The NHA said he spoke to Resident #65 and he said he touched Resident #23 on the shoulder and held her head. The NHA said Resident #65 reported he was consoling Resident #23. The NHA said he did not stop that kind of touching. He said when talking to Resident #65, he said he would sit with Resident #23 and talk to her. He said Resident #65 said Resident #23 talked to him all the time. The NHA said Resident #65 said Resident #23 liked being consoled and spoken to. He said Resident #65 said he talked to Resident #23 about the weather. The NHA said he did not think that Resident #65 intended to touch Resident #23 inappropriately. He said he reported and investigated the sexual abuse. He said he only had one CNA who witnessed the inappropriate behaviors. He said Resident #65 had not had any other behaviors noted. The NHA said the only reason why he instructed the staff to keep the two residents separated was because Resident #23s representative had requested no contact between the two. He said Resident #65 had the right to walk down any hallway because it was his home too. He said if Resident #65 looked into Resident #23's room it was alright. He said he talked to staff all the time about making sure that care plans were updated and documentation was completed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#13) of one resident reviewed for assistance with activities of daily living (ADL) out of 46 sample residents received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure Resident #13 received assistance with ADLs, in the areas of dressing, personal hygiene and eating, in accordance with her comprehensive care plan. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) policy, revised 1/2023, was provided by the nursing home administrator (NHA) on 7/18/24 at 5:21 p.m. It revealed in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following ADLs: bathing, dressing, grooming and oral care, transfer and ambulation, toileting, eating, to include meals and snacks, and using speech, language or other functional communication systems. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. II. Resident #13 A. Resident status Resident #13, age 79, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included lumbar spondylosis (abnormal wear on the cartilage and bones in the neck causing pain), chronic obstructive pulmonary disease (COPD) (damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), hypertension, unspecified dementia without behavioral disturbance and muscle weakness. The 5/1/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. She required partial to moderate assistance with dressing, minimal assistance with transferring and set up assistance for eating. The assessment revealed Resident #13 did not have any episodes of rejecting care. B. Resident observations and interviews (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 10:47 a.m. Resident #13 was lying in bed wearing a hospital gown. Her breakfast was sitting on the overbed table in front of her, not eaten. The fitted sheet under her was off the bottom half of the bed with her legs directly on the mattress and uncovered. At 2:15 p.m. Resident #13 was lying in bed wearing a hospital gown. Her lunch was sitting on the overbed table in front of her, not eaten. The fitted sheet was still off the lower half of the bed with her legs directly on the mattress and uncovered. On 7/16/24 at 8:45 a.m. Resident #13 was lying in bed wearing a hospital gown. Her breakfast plate was on her overbed table in front of her. She was not eating. At 11:23 a.m. Resident #13 was lying in bed wearing a hospital gown. Her breakfast plate had been removed but there was a fork and breakfast food on the floor. At 12:43 p.m. Resident #13 was lying in bed wearing a hospital gown. Her lunch was on the overbed table in front of her with a small amount eaten. There was cake in a bowl by her lunch plate with plastic wrap still covering it. At 2:03 p.m. Resident #13 was lying in bed wearing a hospital gown. The cake was in front of her, with the plastic wrap removed, but none of it was eaten. She said she did not have a fork. There was not a fork observed on her table or on the floor. At 2:53 p.m. Resident #13 was lying in bed on her side facing the wall. She was wearing a hospital gown with her legs uncovered. On 7/17/24 at 9:19 a.m. Resident #13 was in bed wearing a hospital gown. Her breakfast was sitting on the overbed table in front of her. She was eating scrambled eggs with her fingers. There was a package of unopened plastic silverware on her overbed table. At 9:43 a.m. Resident #13 was in bed wearing a hospital gown. Her breakfast plate was on the floor and food was spilled. There was a bowl of dry cereal on the overbed table in front of her and she had no silverware. Her fingernails were observed to be long and had a dark substance under them. Her head was leaning off to the right side of the bed. At 12:56 p.m. an unidentified certified nurse aide (CNA) took lunch into Resident #13's room. The unidentified CNA moved the resident up in bed and raised the head of the bed, Resident #13 was wearing a hospital gown and was not covered with a sheet or blanket. The CNA gave the resident a hand wipe and asked her to clean her hands. The resident wiped her hands minimally and dropped the wipe into her lap. The CNA opened the plastic silverware packet and put the fork in her food. The CNA provided a flat sheet and covered the resident's legs. At 5:30 p.m. Resident #13 was lying flat in bed with beverages on the overbed table in front of her. She was attempting to drink one of the beverages while lying flat in her bed. She was wearing a hospital gown. The gown was rolled up to her chest, her stomach was exposed and her incontinence brief was open. She was not covered with a sheet or blanket. On 7/18/24 at 9:56 a.m. Resident #13 was up in the recliner in her room. She was wearing personal clothing and watching people walk by in the hallway. She said she was comfortable. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:34 p.m. Resident #13 was sitting in the recliner in her room. She had slid down to an almost flat position. She was holding her lunch plate in her lap and was eating with her fingers. A package of unopened plastic silverware was on her overbed table. There was a full piece of sausage on her plate that was not cut up for her. C. Record review The ADL care plan, initiated 2/1/24, documented Resident #13 had an ADL self-care performance deficit related to COPD, fracture of the sacrum, compression fractures, lumbar spondylosis and dementia. The resident required extensive assistance of staff for dressing and extensive to total assistance with personal hygiene. It indicated the resident was independent with eating after set up assistance. -However, observations during the survey revealed Resident #13 had difficulty with eating her food unassisted (see observations above). -The care plan did not indicate Resident #13 ate with her fingers, preferred to wear a hospital gown or preferred to stay in bed during the day and for meals. -The care plan did not indicate that the resident refused assistance with ADLs. -Record review did not reveal Resident #13 refused assistance with dressing or getting out of bed. III. Staff interviews CNA #4 was interviewed on 7/18/24 at 12:30 pm. CNA #4 said the goal was to get Resident #13 dressed and in her chair after breakfast if she agreed. CNA #4 said Resident #13 was able to communicate her preferences. She said Resident #13 usually preferred to wear a hospital gown. CNA #4 said the staff encouraged the resident to get dressed. CNA #4 said the resident was agreeable to getting dressed and out of bed today (7/18/24). -However, Resident #13's plan of care did not indicate that the resident preferred to stay in a hospital gown, rather than getting dressed and being provided personal hygiene assistance. It did not indicate that the resident had episodes of refusing care (see record review above). The director of nursing (DON) was interviewed on 7/18/24 at 2:54 p.m. The DON said morning care included getting the resident up out of bed, changing them or taking them to the bathroom, getting them dressed and assisting with personal hygiene. She said if a resident declined assistance with care in the morning, the CNAs should go back later in the day and offer again. The DON said the staff should encourage residents to get out of bed. The DON said Resident #13 did not always get out of bed. The DON said she had recently tried to assist the resident out of bed and she declined. The DON said the care plan for Resident #13 should reflect her preferences.

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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 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** 50315 Based on observation, record review and interviews, the facility failed to provide an ongoing program of activities for one (#62) of one resident reviewed for activity participation out of 46 sample residents. Specifically, the facility failed to regularly provide individualized, purposeful and therapeutic activities for Resident #62, who was a dependent resident. Findings include: I. Facility policy and procedure The Activities policy, revised October 2022, was provided by the nursing home administrator (NHA) on 7/18/24 at 4:30 p.m. It documented in pertinent part, It is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Group, individual and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental and psychosocial well-being. II. Resident #62 A. Resident status Resident #62, age 74, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), pertinent diagnoses included non-Alzheimer's dementia (memory problems), Parkinson's disease (brain condition that causes uncontrollable movements and coordination problems) and muscle weakness. The 5/14/24 minimum data set (MDS) assessment documented the resident had severely impaired cognitive skills for daily decision making. A staff assessment for mental status revealed he had a memory problem. The MDS assessment documented Resident #62's preferred language was Spanish. He required maximal assistance for transfers and activities of daily living (ADL). The 11/12/23 annual MDS assessment revealed it was very important for the resident to listen to music he liked, be around pets, do his favorite activities, go outside when the weather was good and participate in religious services. A. Observations On 7/15/24 at 3:15 p.m. Resident #62 was sitting in his wheelchair in his room. He had his eyes open and there was no television or music playing. At 4:01 p.m. the resident was assisted to the hallway by an unidentified CNA. The CNA did not provide the resident with any meaningful activities. Resident #62 began sleeping in his wheelchair. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 during a continuous observation, beginning at 2:25 p.m. and ending at 4:38 p.m., the following was observed: At 2:25 p.m. Resident #62 was sitting in his wheelchair with his eyes open and his head facing the floor. He was positioned in the hallway by the dining room with no meaningful activities. Several staff members walked by him without acknowledging him. At 3:29 p.m. two unidentified certified nursing aides (CNA) assisted him into his room. The CNAs provided incontinence care and left him in the room when finished. His wheelchair was facing the window and there was no television or music playing. His head was facing down and his eyes were closed. -There was a British [NAME] puzzle group activity being offered at 2:30 p.m., however, the resident was not invited to attend. -There was an Emoji meaning group activity at 3:00 p.m., however, the resident was not invited to attend. At 4:10 p.m. an unidentified CNA assisted him into the dining room for dinner. On 7/17/24 during a continuous observation, beginning at 1:10 p.m. and ending at 3:19 p.m., the following was observed: At 1:10 p.m. Resident #62 was sitting in his wheelchair in his room with his eyes open. There was no music or television playing. At 2:02 p.m. two unidentified CNAs walked into the resident's room and provided incontinence care to the resident. They left him in the room once they were finished providing care and did not provide him with any meaningful activities. A housekeeper entered the resident's room to clean at 2:21 p.m. -No other staff members entered the room during the continuous observation. -There was a watercolor painting group activity at 2:00 p.m., however, the resident was not invited to attend. -There was a Discovering [NAME] dice game group activity offered at 3:00 p.m., however, the resident was not invited to attend. B. Record review The activities care plan, initiated 5/22/24, identified Resident #62 expressed individual activity interests including independent activities, such as people watching, propelling himself throughout the facility, chewing gum, snacking, dice games, listening to Spanish music, visiting with others (conversations in Spanish) and visiting with family. He liked pets, such as dogs, and would accept one on one visits. Interventions included inviting Resident #62 to group activities, encouraging family involvement, introducing him to residents with similar backgrounds and interests and assisting him to and from activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #62's one-on-one activity participation records revealed the following: In April 2024 (4/1/24 to 4/30/24) five informal one-on-one visits were documented. -The resident received activities during five out of a possible 30 days. In May 2024 (5/1/24 to 5/31/24) nine informal one-on-one visits were documented. -The resident received activities during nine out of a possible 31 days. In June 2024 (6/1/24 to 6/30/24) three informal one-on-one visits were documented. -The resident received activities during three out of a possible 30 days. In July 2024 (7/1/24 to 7/18/24) there were zero informal one-on-one visits documented. -The resident received activities during zero out of a possible 18 days. A review of the resident's electronic medical record (EMR) from 4/1/24 to 7/18/24 did not reveal any documentation related to the resident refusing to participate in individual or one-on-one activities. An activity assessment completed on 11/9/22 documented the resident enjoyed listening to music, being around animals, doing his favorite activities, going outside when the weather was good and participating in religious activities (Christian Spanish music). III. Staff interviews CNA #2 was interviewed on 7/18/24 at 1:00 p.m. CNA #2 said she never saw Resident #62 participate in activities. She said Resident #62 sat in his wheelchair most of the day in his room or the hallway. Registered nurse (RN) #1 was interviewed on 7/18/24 at 1:10 p.m. RN #1 said Resident #62 did not participate in many group activities. She said he liked to watch people as they walked by and propel himself around the hallways in his wheelchair. The activities director (AD) was interviewed on 7/17/24 at 3:22 p.m. The AD said Resident #62 enjoyed people watching, propelling himself around in his wheelchair, one-on-one discussions and listening to music. She said he was on their one-on-one program, which involved him participating in three one-on-one activities per week. She said the resident was not getting all the one-on-one visits due to a lack of activities staff. The AD said Resident #62 primarily spoke Spanish and the facility did not have a translator to be used in a conversation. She said the staff used pages with words in English and Spanish to communicate with the resident or relied on other staff members who spoke Spanish to translate.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#84) of three residents reviewed for pressure injuries out of 46 sample residents received care consistent with professional standards of practice to prevent pressure injuries. Specifically, the facility failed to implement timely interventions to prevent Resident #84 from developing a Stage 2 pressure injury to his coccyx. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from https://www.internationalguideline.com/guideline on 7/22/24, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy The Pressure Injury Prevention policy, revised March 2024, was provided by the nursing home administrator (NHA) on 7/18/24 at 5:21 p.m. It read in pertinent part, To prevent formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present, Individualized interventions will address specific factors in the resident's risk assessment, skin assessment and any pressure injury assessment (for example, moisture management, impaired mobility, nutritional deficit, staging and wound characteristics), The goal and preferences of the resident and/or authorized representative will be included in the plan of care. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care, and will notify the physician to obtain orders. Interventions will be documented in the care plan and communicated to all relevant staff, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance with interventions will be documented in the medical record. III. Resident #84 A. Resident status Resident #84, age 76, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included acute respiratory failure with hypoxia (low oxygen level), type 2 diabetes mellitus , Parkinson's disease with dyskinesia (uncontrolled involuntary muscle movements) and vascular disorder of the intestine (narrowing or blockage of the arteries that supply blood to the intestines). According to the 6/27/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The resident was dependent for all activities of daily living (ADL) including transfers and bed mobility and was always incontinent of bowel and bladder. The assessment revealed the resident was at risk for developing pressure ulcers but did not have a pressure ulcer at the time of his admission to the facility. He had a pressure reducing device for his chair and bed, was on a turning and repositioning program and received applications of ointments/medications other than to the feet. The assessment did not indicate the resident had any behaviors of rejecting care. B. Resident representative interview Resident #84's representative was interviewed on 7/15/24 at 4:15 p.m. The representative said the facility staff did not come in every two hours to provide incontinence care or reposition Resident #84. She said she sat with the resident every day. She said the facility staff would only enter the room when she pushed the call light. She said the facility had never provided Resident #84 with an air mattress (pressure redistribution mattress). C. Observations On 7/16/24 at 11:33 a.m. Resident #84 was lying in bed. -There was not an air mattress on the bed. On 7/17/24 1:47 p.m. Resident #84 was lying in bed and the resident representative was at the bedside. -There was not an air mattress on the bed. On 7/18/24 at 8:45 a.m. Resident #84 was observed lying in bed. Licensed practical nurse (LPN) #2 and registered nurse (RN) #3 were preparing to perform the resident's wound care. -There was not an air mattress on the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 turned the resident to one side while LPN #2 removed the bordered gauze covering the wound. LPN #2 cleansed the wound, exposing a pink wound bed with no slough (yellow/white material containing dead cells that accumulate over a wound bed). The wound size was approximately 2 centimeters (cm) wide by 2 cm long. D. Record review The baseline care plan, initiated 6/21/24, documented Resident #84 was incontinent of bowel and bladder and required total assistance from staff for repositioning in bed. -The care plan did not identify that the resident was at risk for developing pressure injuries or document any pressure wound preventative measures that were put in place. According to the admission assessment, completed 6/21/24, Resident #84 had multiple bruises and scabs to his arms and bruises on his abdomen. There was no pressure injury documented on the admission assessment. According to the Braden pressure ulcer risk assessment (a tool utilized to determine pressure ulcer risk), completed on 6/27/24, the resident was at risk for pressure injuries due to very limited mobility, being bedfast and the potential for friction and shear during repositioning. The skin assessment completed on 6/27/24 indicated the resident had no pressure injuries. The nursing progress note dated 7/4/24 documented Resident #84 had an open area to the coccyx with no drainage or redness noted to the area. A treatment order was obtained on 7/4/24 to cleanse the open area to the coccyx and cover with border gauze dressing every other day. The interdisciplinary team (IDT) progress note on 7/5/24 at 8:53 a.m., documented Resident #84 had a small wound on his coccyx. The recommendations included adding an alternating low loss air mattress and the wound care physician was to follow. -Review of Resident #84's electronic medical record (EMR) revealed a risk for pressure ulcer care plan was not initiated until 7/10/24 (20 days after the resident's admission to the facility and six days after the pressure ulcer was initially identified). The risk for pressure ulcer care plan indicated Resident #84 was at risk for pressure ulcers related to immobility, incontinence and cognitive deficits. Interventions included administering medications as ordered, monitoring/documenting for side effects and effectiveness, educating the resident, family, and caregivers as to causes of skin breakdown, including positioning requirements, good nutrition and frequent repositioning, encouraging the resident to turn side-to-side, monitoring nutritional status, monitoring and documenting changes in skin status and obtaining and monitoring laboratory/diagnostic work as ordered. -The care plan did not indicate the presence of an active pressure ulcer. It did not include interventions for wound care treatment, using a specialty mattress or frequent repositioning of the resident by staff. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing wound assessment dated [DATE] indicated the wound was identified on 7/6/24. Interventions included a pressure redistribution mattress, a wheelchair cushion, vitamin supplements and positioning devices. The assessment documented that the care plan was updated. -However, according to the nurse progress notes, the wound was initially identified on 7/4/24 (see progress notes above). -Additionally, the facility failed to ensure the care plan, which was not implemented until 7/10/24 (six days after the pressure injury was identified), was to include the pressure injury or interventions. -The facility failed to implement the air mattress which was a documented intervention on the wound assessment (see observations above). According to the wound physician's (WP) progress note dated 7/10/24, Resident #84 had an unstageable pressure injury to the coccyx, due to necrosis (death of tissue) with full thickness measuring 1.5 cm wide by 15 cm long by 0.2 cm deep. The physician's treatment order was changed on 7/10/24 to cleanse the area to the coccyx, apply Medi-honey to the wound bed and cover with bordered gauze dressing every day. The nursing wound observation note dated 7/10/24 revealed Resident #84's pressure wound on the coccyx measured 1.5 cm long by 1.5 cm in wide by 0.2 cm in deep and was unstageable. The note documented the care plan was reviewed, the physician was notified of changes, resident education was provided and the resident's representative was updated with changes. It noted that the wound was unresolved and was acquired after admission. -The measurements documented on the wound observation were significantly different from the WP progress note (see WP progress note above). IV. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 7/18/24 at 1:00 p.m. CNA #3 said when a resident was at risk for developing pressure ulcers, she repositioned the resident every two hours and applied barrier cream to their skin. CNA #3 said she was not aware that Resident #84 had a pressure ulcer. LPN #2 was interviewed on 7/18/24 at 1:04 p.m. LPN #2 said when a new pressure injury was identified, the director of nursing (DON) or the MDS assessment nurse should be notified. She said the DON and the MDS assessment nurse were responsible for initiating the care plan. LPN #2 said the care plan should include interventions, such as incontinence care and repositioning every two hours, or offloading the pressure injury site. LPN #2 said Resident #84 did not have a pressure ulcer when he was admitted to the facility. She said Resident #84 laid in bed most of the time and staff repositioned and provided incontinence care every two hours. She said the resident did not have an air mattress because his family requested the bolstered (with raised sides) mattress for fall prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, there was no documentation in the EMR indicating the resident's family was offered and declined the air mattress. The DON was interviewed on 7/18/24 at 2:54 p.m. The DON said upon a resident's admission to the facility, a Braden scale was completed to determine each resident's risk for developing pressure ulcers. She said if a resident was at risk, interventions, such as frequent repositioning, alternating air mattress, frequent incontinence care and dietitian involvement, were initiated. The DON said a care plan for Resident #84's risk of developing pressure injuries should have been developed upon his admission to the facility. She said the baseline care plan should have identified that the resident was at risk for pressure ulcers and preventative interventions should have been put into place. The DON said, initially, the resident's family did not allow him to get out of bed due to his pain. She said the staff had not done a good job of repositioning the resident until after he developed the pressure ulcer. The DON said the pressure ulcer was not identified on the resident's comprehensive care plan and it should have been. She said there were no interventions put into place until after Resident #84 developed the pressure injury to his coccyx. The DON said the family wanted a bolstered mattress because they were concerned about the resident falling out of bed and they declined the air mattress. She said the facility should have documented in the resident's EMR and comprehensive care plan that the resident's representative declined the air mattress. She said the facility might be able to get bolsters for an air mattress, however, she said they had not looked into it. The wound physician (WP) was interviewed on 7/18/24 at 4:30 p.m. The WP said he only assessed the wound once and it was covered with slough and was unstageable. He said the wound measured about 15 cm long by 1.5 cm wide by 0.2 cm deep. The WP said he understood from staff that the family had declined using the air mattress.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 9.68%, or three errors out of 31 opportunities for error. Finding 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. ,d+[DATE], retrieved on [DATE], 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, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 5:21 p.m. The policy read in pertinent part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection, keep medication cart clean, organized and stocked with adequate supplies, identify expiration date. If expired, notify the nurse manager, correct any discrepancies and report to the nurse manager. III. Manufacturer's Guidelines According to the manufacturer's guidelines for insulin lispro (Humalog), retrieved on [DATE] from https://www.accessdata.fda.gov/drugsatfda_docs/label/,d+[DATE]s172,205747s008lbl.pdf, Humalog is a rapid acting human insulin analog indicated to improve glycemic control in adults with diabetes mellitus. Administer Humalog by subcutaneous (under the skin) injection within 15 minutes before a meal or immediately after a meal. According to the Humalog pen insulin lispro injection instructions retrieved on [DATE] from https://www.accessdata.fda.gov/drugsatfda_docs/label/,d+[DATE]slr046_humalog_lbl.pdf, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The needle must be changed and the pen must be primed before each injection to make sure the pen is ready to dose. Performing these steps before each injection is important to confirm that insulin comes out when you push the injection button, and to remove air that may collect in the insulin cartridge during normal use. According to the manufacturer's guidelines for artificial tears (polyvinyl alcohol 1.4%), retrieved on [DATE] from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=736f9577-d8ff-45c,d+[DATE]-dfdb7193492f, Artificial tears are for use in the eyes as a lubricant to prevent further irritation or to relieve dryness. To avoid contamination, do not touch the tip of the container to any surface. Replace cap after using. IV. Observations and interviews On [DATE] at 3:25 p.m. licensed practical nurse (LPN) #1 was administering medication to Resident #290. Resident #290 had a physician's order for insulin lispro subcutaneous solution pen-injector 200 unit/milliliter; inject three units subcutaneously before meals for diabetes. The insulin should not be given if blood glucose is lower than 150 milligrams/deciliter (mg/dl). After checking the resident's blood sugar, LPN #1 determined that three units of insulin lispro were required. LPN #1 drew up three units in the insulin pen and cleaned the resident's arm with an alcohol swab. -Before she injected the insulin, LPN #1 was stopped from administering the insulin. LPN #1 said she should have primed the insulin pen prior to drawing up the three units. Resident #290 had a physician's order for artificial tears ophthalmic solution 1 %, two drops in both eyes four times a day for dry eyes. LPN #1 took the eye drops from the medication cart and placed them in her pocket. She went to the resident's room, administered an oral medication and insulin. She then returned to her medication cart. Upon prompting, she said she forgot to administer the eye drops. She returned to the resident room and administered the eyedrops. On [DATE] at 9:27 a.m. registered nurse (RN) #1 was preparing medications for Resident #5. The resident had an order for calcium with vitamin D tablet ,d+[DATE] milligrams (mg)-unit. RN #1 said the facility did not have the prescribed dose in stock currently and he would have to contact the transportation coordinator (TC), who ordered the over the counter medications. He did not administer the calcium with vitamin D and made a progress note that it was unavailable. He contacted the TC but did not notify the physician. V. Additional staff interviews (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on [DATE] at 3:30 p.m. She said insulin pens should be primed prior to administering the insulin. She said she did not prime the insulin pen prior to attempting to administer the insulin. LPN #1 said she forgot to administer eye drops to Resident #290. She said she would have noticed the eyedrops were in her pocket at some point in the day. The TC was interviewed on [DATE] at 10:39 a.m. She said she was responsible for tracking over the counter (OTC) medications. She said if a new OTC medication was ordered she would go to a local store and purchase it, then add it to her next supply order. The TC said she was not notified the facility was out of stock of the calcium with vitamin D ,d+[DATE] mg-unit until that day ([DATE]). She said the medication was on backorder and would not be available until [DATE]. The TC said she would pick the medication up at a local store today ([DATE]) to cover until the stock supply came in. The director of nursing (DON) was interviewed on [DATE] at 2:54 p.m. The DON said all medications should be administered according to the physician's orders. She said when an OTC medication was unavailable, the nurse should notify the TC immediately and the physician for clarification. She said it was easy to go to the local store to pick up an OTC medication. The DON said insulin pens should be primed before drawing up a dose of insulin. She said priming the insulin pen was important to ensure the resident received the correct dose of insulin. The DON said nurses should not put medications in their pocket due to infection control concerns.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#290) of nine residents out of 46 sample residents were free from significant medication errors. Specifically, the facility failed to ensure the insulin pen was primed prior to medication administration for Resident #290. 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 7/22/24, 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. Manufacturer's guidelines According to the Humalog pen insulin lispro injection instructions, retrieved on 7/22/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2004/20563slr046_humalog_lbl.pdf, The needle must be changed and the pen must be primed before each injection to make sure the pen is ready to dose. Performing these steps before each injection is important to confirm that insulin comes out when you push the injection button, and to remove air that may collect in the insulin cartridge during normal use. III. Resident #290 status Resident #290, age 75, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus without complications, chronic kidney disease stage three and myocardial infarction (heart attack). According to the 5/29/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required partial to substantial assistance with transfers, dressing and bathing. IV. Observations (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 3:25 p.m. licensed practical nurse (LPN) #1 was administering medication to Resident #290. The medication ordered was Insulin Lispro Subcutaneous (under the skin) Solution Pen-Injector 200 unit/milliliter, inject three units subcutaneously before meals for diabetes. Hold if blood glucose is lower than 150 milligrams/deciliter (mg/dl). After checking the resident's blood sugar, LPN #1 determined that three units of Insulin Lispro were required. LPN #1 drew up three units in the insulin pen and cleaned the resident's arm with an alcohol swab. Before she injected the insulin, LPN #1 was stopped from administering the insulin. -LPN #1 failed to prime the insulin pen per manufacturer's instructions. LPN #1 said she should have primed the insulin pen prior to drawing up the three units of insulin. LPN #1 proceeded to prime the pen and administer three units of insulin to Resident #290. V. Staff interviews LPN #1 was interviewed on 7/16/24 at 3:30 p.m. LPN #1 said she should have primed the insulin pen prior to drawing up the three units of insulin. LPN #1 said she had recently received training on priming insulin pens. The director of nursing (DON) was interviewed on 7/18/24 at 2:54 p.m. The DON said insulin pens should be primed prior to drawing up the dose of insulin to remove air that may have collected in the insulin cartridge and ensure the correct dose was given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 one of four medication carts and one of two medication storage rooms. Specifically, the facility failed to: -Ensure a vial of Tubersol (used to test for tuberculosis) was discarded 30 days after it was opened; and, -Ensure expired medications were removed from the medication cart. 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 7/23/24 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. Manufacturer's guidelines According to the Tubersol package insert, retrieved on 7/23/24 from https://www.fda.gov/media/74866/download, A vial of tubersol which has been opened and in use for 30 days should be discarded. III. Observations On 7/17/24 at 5:14 p.m. the medication cart on the Diamond Way hall was observed with registered nurse (RN) #1. The following items were found: -A bottle of calcium 600 milligrams (mg) with vitamin D5 with an expiration date of June 2024; and, -A bottle of Fluticasone Propionate 50 micrograms (mcg) nasal spray with an expiration date of April 2024. On 7/17/24 at 5:33 p.m. the East medication storage room was observed with RN #3. The following item was found: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A vial of Tubersol solution with an opened date of 6/11/24. -According to the manufacturer's guidelines (see above), the Tubersol should have been discarded on 7/12/24. IV. Staff interviews RN #1 was interviewed on 7/17/24 at 5:14 p.m. RN #1 said the medications in the Diamond Way hall medication cart were expired and he would dispose of them. RN #3 was interviewed on 7/17/24 at 5:33 p.m. RN #3 said the Tubersol should have been discarded 30 days after it was opened. She said she would notify the director of nursing (DON). The DON was interviewed on 7/17/24 at 5:53 p.m. The DON said medications should be discarded when expired. She said the vial of Tubersol should have been discarded 30 days after it was opened.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48114 Based on observations, record review and interviews, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value and were palatable in taste, texture and temperature. Specifically, the facility failed to ensure the resident's food was palatable in taste, texture and temperature. Findings include: I. Facility policy and procedure The Food Preparation Guidelines policy, revised 1/2023, was provided by the nursing home administrator (NHA) on 7/18/24 at 5:20 p.m. It read in pertinent part, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes. Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include using spices or herbs to season food in accordance with recipes, serving hot foods/drinks hot and cold foods/drinks cold and addressing resident complaints about foods/drinks. II. Resident interviews Resident #41 was interviewed on 7/15/24 at 9:33 a.m. Resident #41 said the food was bad. She said the vegetables were mushy. She said she tried to eat a low carbohydrate diet but it was difficult with the facility menu. Resident #25 was interviewed on 7/15/24 at 10:26 a.m. Resident #25 said the food was cold. She said the facility served the same thing (burritos) every day. She said she had talked to the dietitian and it did not help. She said the alternative menu consisted of the same food and it did not change. Resident #64 was interviewed on 7/15/24 at 11:20 a.m. Resident #64 said the food tasted terrible. He said the food had no seasoning to it and was tough to chew. Resident #53 was interviewed on 7/15/24 at 11:33 a.m. Resident #53 said the food was bad. He said the food was always too spicy. He said the facility served a lot of potatoes. He said the sandwiches only had one slice of meat on them. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #51 was interviewed on 7/15/24 at 4:01 p.m. Resident #51 said sometimes the food was good and other times the food tasted bad. She said she ordered off the alternative menu all the time. She said the alternative menu could stand to be updated by adding new food items because she was tired of the options on the alternative menu. Resident #59 was interviewed on 7/15/24 at 4:27 p.m. Resident #59 said the food was terrible and was always cold. Resident #47 was interviewed on 7/15/24 at 4:53 p.m. Resident #47 said the food was undercooked. He said he had found hair in his food and the bread was moldy. III. Observations On 7/17/24 during a continuous observation of the dinner meal preparation and service in the main kitchen, beginning at 2:20 p.m. and ending at 5:52 p.m., the following was observed: At 3:52 p.m. the cook (CK) poured butter on the grill and began cooking the peppers on the stove to grill them. He said once the peppers were softened he would add the onions. At 3:58 p.m. the CK added the onions. He said he did not add any seasoning to the bell peppers and onions. At 5:52 p.m. the last tray was plated and placed in the insulated meal tray transport box. The insulated box was taken down the east hallway and the meals were served to the residents IV. Test tray On 7/17/24 at 6:06 p.m. a test tray was evaluated by four surveyors immediately after the last resident had been served their room tray for dinner. The regular diet test tray consisted of a sausage and veggie skillet, scalloped potatoes, garden salad with dressing, a roll and mandarin oranges. -The temperature of the ground sausage and peppers was 100.4 degrees Fahrenheit (F). The ground sausage and peppers felt lukewarm when consumed -The temperature of the scalloped potatoes was 119 degrees F. The scalloped potatoes were dry and hard as the potatoes were not cooked all the way through. The potatoes were bland. V. Record review The food committee meeting minute notes were received from the NHA on 7/17/24 at 12:35 p.m. The 2/9/24 food committee meeting minute notes documented one resident wanted less Spanish food and another resident requested more fruit. The residents were informed that due to the cold weather, fresh fruit was hard to get. The outcome documented the residents were overall satisfied with the dining experience. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The 2/9/24 food committee notes did not include how the facility was going to handle the suggestion of offering less Spanish food on the menu. V. Staff interviews The dietary manager (DM) was interviewed on 7/18/24 at 12:03 p.m. The DM said when he was informed that a resident had a concern or issue with the foods being served to them, he would talk to them and find out what they did not like. He said he would offer the resident something else to eat. He said the certified nurse aides (CNA) were responsible for taking the resident's meal orders. He said the CNAs asked the residents if they wanted what was being served on the ticket and, if not, then the CNAs would offer something from the alternative menu. The DM said the kitchen staff received the meal tickets two to three hours before meal service. He said all the residents should have an alternative menu in their room so it was readily available to them. The DM said he had received some food concerns regarding temperatures from the hallway trays. He said residents had complained about the food being delivered to their rooms cold as he only had insulated carts. He said some of the complaints were the residents did not like some of the foods being served. He said he had not heard of any complaints about the food being bland. He said he had a plan in place and was trying to get more residents to come and eat in the dining room. The DM said the food committee met once a month. He said the monthly meeting had been effective but he said he would like to get more residents to attend the meetings. He said he tried to promote the food committee to encourage more residents to attend. He said he was in charge of addressing the food concerns. He said as soon as he heard of a food complaint, he addressed them immediately. He said when he was told about a concern, he would ask the residents and the resident would tell him that everything was fine. He said he told the residents if they had a concern to let him know so he could fix the problem. He said if he did not know what the problem was he could not fix it. He said that he did not get many food concerns. The DM said he had not heard of any concerns about the food being over cooked, vegetables being mushy, food being greasy and the food tasting bad. He said he had temperature logs and he checked them daily to make sure they were correct. He said he checked the temperatures at the beginning of the meals, sometimes in the middle and checked trays randomly. He said he tasted all the food every day to make sure that it was not overcooked or undercooked. He said the food came down to preference and everyone had different preferences. He said he would keep an eye out on how the cooks were preparing the meals and talk to them and educate them. The DM said the trays being transported to the hallways were transported in an insulated box and were not hot boxes. He said he had two insulated boxes and they did not plug in to be kept heated. He said corporate management had bought the insulated boxes. He said he had mentioned getting hot boxes that plugged into the wall to the NHA. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 7/18/24 at 12:42 p.m. The NHA said the room tray carts were not heating carts. He said the carts held the heat for approximately 45 minutes. He said he did not know that there were hot boxes that plugged into the wall to stay warm. He said he would talk to the DM and ask him if he wanted the plugged in hot boxes and he would buy it. He said the room trays should be served to the residents as soon as possible. He said he had a performance plan in place of not meeting food temperatures and making sure the concerns were being met. He said he had a plan to bring all the residents back to the dining room. He said he would love to see more residents eating in the dining room and not in their rooms The NHA said he looked at the grievance binder every day. He said he did not get a lot of food concerns and had not gotten any within the last month.

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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 two of four hallways. Specifically, the facility failed to: -Ensure enhanced barrier precautions (EBP) were implemented and followed for residents with wounds and/or indwelling medical devices; -Ensure residents' laundry was appropriately covered during transportation; and, -Ensure housekeeping used the proper cleaning method to sanitize a residents' rooms. Finding include: I. Failure to implement and follow EBP for residents with wounds and/or indwelling medical devices A. Facility policy and procedure The Enhanced Barrier Precautions policy, revised 12/2022, was received by the nursing home administrator (NHA) on 7/18/24 at 5:16 p.m. It documented in pertinent part, It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms. Prompt recognition of need: Clear signage will be posted on the door or wall outside of the residents' room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Initiation of EBP: an order for EBP will be obtained for residents with any wound and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). Implementation of EBP: make gowns and gloves available immediately outside of the resident's room. High contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. B. Resident observations and interviews On 7/15/24 at 4:35 p.m. Resident #82 was observed in his room. He had a foley catheter drainage bag hanging on his bed. -There were no signs for EBP hanging outside the resident's room or on the door (see facility policy above). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no PPE located outside the resident's room (see facility policy above). Resident #82 was interviewed on 7/15/24 at 4:47 p.m. Resident #82 said staff helped him with many cares since he broke his shoulder and leg. He said they did bed baths, changed his briefs, emptied his foley catheter drainage bag, dressed him and got him up to the wheelchair. He said the staff wore gloves, but not gowns, when providing his care. He said he had had an indwelling catheter for a long time. On 7/18/24 at 8:45 a.m. Resident #84 was observed lying in bed. Licensed practical nurse (LPN) #2 and RN #3 were preparing to perform the resident's wound care. The door to the resident's room had signs indicating the resident was on EBP. -LPN #2 and RN #3 entered the resident's room without donning gowns. RN #3 turned Resident #84 to one side while LPN #2 removed the resident's old wound dressing. LPN #2 cleansed the wound and applied a new dressing to the wound. LPN #2 and RN #3 said they did not know why the resident was on EBP. C. Staff interviews The infection preventionist (IP) and director of nursing (DON) were interviewed on 7/18/24 at 10:00 a.m. The IP said any resident with open wounds or indwelling medical devices, such as a gastrostomy tube (feeding tube), intravenous device (IV), or catheters, would be placed on EBP. He said the residents should have a sign outside their door and a cart with PPE outside their room, which was how the facility chose to identify residents who were on EBP. Certified nurse aide (CNA) #2 was interviewed on 7/18/24 at 11:45 a.m. CNA #2 said residents on EBP were supposed to have a sign outside their door. She said the sign was how she knew that the resident was on EBP and she would put a gown and gloves on before providing resident care. She said if the resident did not have a sign outside their door, she would not put a gown and gloves on unless told otherwise CNA #2 said she had not been told Resident #82 was on EBP. Registered nurse (RN) #1 was interviewed on 7/18/24 at 11:50 a.m. RN #1 said residents were on EBP if they had a MDRO and if they had a wound or indwelling medical device, even if they did not have a MDRO. He said he put a gown and gloves on while providing care for residents on EBP II. Failure to use proper cleaning method when sanitizing residents' rooms A. Facility policy and procedure The 5-step Daily Patient Room Cleaning Guide, undated, was received from the housekeeping director (HSKD) on 7/17/24 at 4:45 p.m. It documented in pertinent part, The purpose is to show housekeeping employees the proper cleaning method to sanitize a patient's room or any area in a healthcare facility. Horizontal surfaces include disinfecting tabletops, headboards, window sills and chairs. Vertical surfaces are not wiped down daily but must be spot cleaned daily. Walls especially by trash cans, light switches and door handles will need special attention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations Housekeeper (HSK) #1 was observed on 7/16/24 at 12:19 p.m. HSK #1 was cleaning resident rooms on the [NAME] hallway. He cleaned the bedside table and television for bed A in room [ROOM NUMBER], switched out rags and cleaned the bedside table for bed B. He then cleaned the sink and paper towel dispenser. He cleaned the bathroom and swept the bedroom floor. After cleaning in room [ROOM NUMBER], HSK #1 then moved on to room [ROOM NUMBER]. He cleaned the bedside table for bed A. He said he was not going to clean the bedside table for bed B because that resident did not eat in the room much. He cleaned the sink and paper towel dispenser. He cleaned and mopped the bathroom. -HSK #1 swept and mopped the entire bedroom using the same dust mop and damp mop he had just used to sweep and mop the bathroom floor. -HSK #1 failed to clean the high-touch surfaces in the residents' rooms and mop the bedroom floor in room [ROOM NUMBER]. -HSK #1 failed to treat room [ROOM NUMBER] as separate areas when using the damp mop. -HSK #1 failed to clean bed B's bedside table in room [ROOM NUMBER]. HSK #2 was observed on 7/17/24 at 11:04 a.m. cleaning resident rooms on the East hallway. He cleaned the bedside table and television for bed A in room [ROOM NUMBER], switched out rags, and cleaned the bedside table for bed B. He then cleaned the sink and paper towel dispenser. He cleaned the bathroom and swept and mopped the bedroom floor. He then moved on to room [ROOM NUMBER]. He cleaned the bedside table for bed A, switched out rags, and cleaned the bedside table for bed B. He cleaned the sink and paper towel dispenser. He cleaned and mopped the bathroom. -HSK #2 swept and mopped the entire bedroom using the same dust mop and damp mop he had just used to sweep and mop the bathroom floor. -HSK #2 failed to clean the high-touch surfaces in the residents' rooms. -HSK #2 failed to treat rooms #33 and #31 as separate rooms when using the damp mop. C. Staff interview The housekeeping director was interviewed on 7/17/24 at 4:45 p.m. He said when cleaning a resident room with two sides, it should always be treated as two separate rooms. He said high touch surfaces should be cleaned daily. He said high touch surfaces included call lights, door handles, light switches, and phones. III. Failure to ensure residents' laundry was appropriately covered during transportation A. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Infection Prevention and Control Program policy, revised 12/2022, was received by the NHA on 7/15/24 at 10:00 a.m. The policy documented in pertinent part, The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Clean linen shall be delivered to the resident care units on covered linen carts with covers down. B. Observation An unidentified HSK was observed on 7/17/24 at 12:03 p.m. The HSK was dropping personal laundry off to residents' rooms. The laundry transport cart was overflowing with laundry and only the top part of the cart had a white sheet covering it. The bottom of the cart was enclosed with bars, but there were spaces between the bars with exposed laundry. The HSK took the sheet off the top of the laundry transport cart to expose the laundry, took out clothing, and walked into the resident's room to hang it up. She came out, moved the cart to the next room and took clothing out to give to the next resident. The HSK failed to replace the sheet over the remaining clean laundry as she continued delivering the laundry to residents' rooms. C. Staff interview The HSKD was interviewed on 7/17/24 at 4:45 p.m. He said clean linen and residents' laundry should always be covered during transportation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure resident rooms, bathrooms and hallways received necessary maintenance repairs. Findings include: I. Observations and resident interviews Observations throughout the survey were conducted on 7/15, 7/16, 7/17 and 7/18/24 and revealed the following: A. Individual resident rooms room [ROOM NUMBER] had a leaking toilet and the tile on the bathroom floor on the corner edge under the sink was coming off the floor. The bathroom smelled like urine and mildew. The towel rack in the bathroom was not labeled. The bathroom was shared with another resident. In room [ROOM NUMBER], the soap dispenser in the bathroom was broken and the resident had hand sanitizer to wash her hands. -The resident said she reported the broken soap dispenser to staff two weeks ago and was waiting for it to be fixed. The resident who resided in room [ROOM NUMBER] said every time it rained, water would come in from the bottom of the double doors in his room that led out to the courtyard. -There was no weatherstripping at the bottom of the doors to prevent water from coming in. room [ROOM NUMBER] was hot and there was no air conditioner in the room. The resident had a fan on but it was still hot. The resident said he was sweating and even with the fan he had on he said he was still hot. The heater vent in room [ROOM NUMBER] was coming off the wall by the window, the wall behind the head of the bed was patched and needed to be painted. One of the individual slats was broken and missing. The blinds in room [ROOM NUMBER] had one of the individual slats that was broken and missing. There was a broken tile as you entered the bathroom in room [ROOM NUMBER]. B. Hallways (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was an outlet that was coming off the wall in the west hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. The baseboard was coming off the wall in the east hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. C. Shower rooms Observations of the four shower rooms were completed on 7/16/24. -The big shower room down the east hallway the paint was chipping as you entered the shower. The transition floor piece as you entered the bathroom from the hallway was missing and there was a gap. -The big shower room down the west hallway had three wet towels left on the floor of the shower. II. Facility environmental tour and staff interviews An environmental tour was conducted on 7/18/24 at 10:05 a.m. with the maintenance assistance (MA). Regarding all observations above, the MA said he was going around and fixing/repairing all the items that needed repaired or fixed while on survey. He said he walked the facility every day he was there to look for items that needed to be repaired. He said patching the walls and painting was an ongoing project. He said he saw the areas that needed to be repaired and was working on getting the repairs done. The MA said he was notified of work orders by a work maintenance program that staff had access to. He said the program sent him the work orders. He said he looked at the work orders everyday. He said the staff would also notify him in person on what needed fixing. He said he was working on getting all the repairs completed. He said he focused on one hallway at a time and, depending on how bad some rooms were, he would get to them first. The MA said the maintenance department was the only department who did walk-throughs of the building to determine what needed to be fixed. He said if he ran into any issues he would notify the administrator.