STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065193	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to honor resident choices for five (#35, #39, #6, #23 and #33) of 28 residents out of 41 sample residents. Specifically, the facility failed to honor Resident #35, Resident #39 and Resident #6, Resident #23 and Resident #33's preferences including shower frequency and times. Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, revised December 2021, was received from the nursing home administrator (NHA) on 12/19/24 at 11:54 a.m. It revealed in pertinent part At the time of admission and periodically throughout their stay, the facility will inform each resident, orally and in writing, of their rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has the right to reside and receive services in the facility with reasonable accommodations of resident preferences except when to do so would endanger the realty and safety of the resident or other residents. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The Bath, Shower/Tub policy, revised February 2018, was provided by the director of clinical services (DOCS) on 12/17/24 at 6:58 p.m. The policy read in pertinent part, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The date and time the shower/tub bath was performed, the name and title of the individual(s) who assisted the resident, all assessment data, if the resident refused the shower/tub bath, the reason(s) why and the intervention taken, the signature and title of the person recording the data. Notify the supervisor if the resident refuses the shower/tub bath. II. Resident #35 A. Resident status Resident #35, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included chronic kidney disease, type 2 diabetes mellitus and major depressive disorder. The 10/16/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff assistance with transfers, toileting, dressing and showering. She did not have any behaviors or refusals of care. B. Resident interview Resident #35 was interviewed on 12/18/24 at 9:09 a.m. Resident #35 said she wanted to have a shower at least once a week. She said she had not had a shower in the past four weeks. Resident #35 did not know why she was not given a shower weekly as she requested. She said she was incontinent of bowel and bladder and she often felt dirty and like no one cared about her when she did not receive her showers. C. Record review A review of Resident #35's bath record revealed the resident last received a shower on 11/18/24. Documentation did not reveal the resident had refused any showers. On 11/25/24, 11/28/24, 11/30/24 and 12/5/24 the residents shower was documented as not applicable. III. Resident #39 A. Resident status Resident #39, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, diagnoses included congestive heart failure, chronic respiratory failure and chronic kidney disease. The 10/30/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with transfers, toileting, and dressing and required supervision with showers. She did not have any behaviors or refusals of care. B. Resident interview (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39 was interviewed on 12/18/24 at 9:10 a.m. Resident #39 said she did not get two showers a week as she preferred. She said she knew it bothers her roommate because she made the room smell bad. Resident #39 said it made her feel bad when she smelled bad and like no one at the facility cared about her. She said she only refused showers when they were offered in the morning because she preferred to have them in the late afternoon or evening. C. Record review A review of Resident #39's bath record revealed the resident received four showers in the past 30 days on 11/20/24, 11/27/24, 11/29/24 and 12/11/24. The resident refused showers on 11/17/24, 11/24/24, 12/1/24 and 12/4/24. Showers were documented as not applicable on 11/13/24, 11/15/24, 11/22/24, 12/6/24 and 12/8/24. 20287 IV. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included atherosclerotic heart disease, borderline personality disorder and chronic obstructive pulmonary disease (COPD). The 10/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for showers. C. Resident interview Resident #6 was interviewed on 12/11/24 at 3:15 p.m. Resident #6 said she had requested a shower three times a week. The resident said she typically received her shower on Sundays, however she did not always receive the other two. She said it was related to staffing. C. Record review The care plan last updated on 7/30/24 identified the resident had a self care deficit related to activity intolerance, morbid obesity and COPD. Pertinent interventions included the resident preferred her showers on Wednesday and every other day in the mid day. The 10/27/23 personal bathing preference form documented the resident preferred to bathe three times a week. -However, the care plan indicated the resident liked to shower every other day. The care plan last updated on 7/30/24 identified the resident had a self care deficit related to activity intolerance, morbid obesity and COPD. Pertinent interventions included the resident preferred her showers on Wednesday and every other day in the mid day. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The bath records for November 2024 (11/1/24 to 11/30/24) revealed the resident received eight (11/3/24, 11/10/24, 11/12/24, 11/14/24, 11/19/24, 11/24/24, 11/26/24 and 11/28/24) showers out of 12 opportunities for three times a week. D. Resident group interview A group interview was conducted on 12/17/24 at 1:05 p.m. with five residents (#115, #28, #4, #16, and #17) who were interviewable based on assessment and facility. The residents said they did not get a choice on how many showers they received or the time of day they received their showers. The residents said they were lucky to get one shower a week. E. Staff interview The director of nursing (DON) was interviewed on 12/17/24 at 6:10 p.m. The DON said when a resident was admitted to the facility the resident filled out a preference sheet form that indicated how many showers a week they would like. She said the residents should get as many showers as they had requested. The DON said she identified the staff were not documenting showers and was going to develop a plan to provide staff education regarding documentation of showers received. 48458 IV. Resident #23 A. Resident status Resident #23, age 69, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included hemiplegia (paralysis or weakness on one side of the body), malnutrition, peripheral vascular disease (circulation condition with narrowing of blood vessels) and neurogenic (nerve) dysfunction of the bladder. The 9/26/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required set-up assistance from staff with oral hygiene, supervision for toileting and substantial to moderate assistance with showering/bathing. B. Resident interview and observation Resident #23 was interviewed on 12/11/24 at 11:56 a.m. Resident #23 said he had not had a shower in two weeks because the facility did not have enough staff to help him shower. Resident #23 said he had been using wipes to wash himself. He said he was supposed to have a shower twice per week and he needed help to get him into the shower each time. C. Record review Resident #23's care plan, revised 4/8/24, revealed Resident #23 preferred to shower on Monday, Wednesday and Fridays and he required supervision by one staff member. Review of the shower schedule posted at the nurse's station revealed Resident #23 was scheduled to receive showers every week on Monday and Friday. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, Resident #23's care plan indicated he preferred to shower Monday, Wednesday and Friday. Resident #23's bathing/showering record from 9/1/24 to 11/30/24 was provided by the DOCS on 12/17/24 at 1:33 p.m. The bathing/shower records provided and the treatment administration record (TAR) for December 2024 were reviewed from 10/16/24 to 12/16/24. The records revealed the following: Resident #23 refused one shower on 11/4/24. -There was no other documentation to indicate Resident #23 had refused other scheduled showers. Per the bathing/showering record documentation from 10/16/24 to 12/16/24, Resident #23 received eight showers out of 16 opportunities. There was no documentation indicating the resident had received a shower since 11/29/24, indicating the resident had not received a shower in 17 days. -Other than the documented refusal on 11/4/24, review of the resident's bathing records revealed no documentation to indicate why the resident missed his showers or what interventions were attempted for Resident #23's missed showers. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 12/17/24 at 10:38 a.m. CNA #4 said Resident #23 required assistance with showering. She said Resident #23 liked showering and did not refuse them. CNA #1 said it did not surprise her that Resident #23 had not received regular showers as there was not always enough staff to provide showers to every resident. CNA #3 was interviewed on 12/17/24 at 10:56 a.m. CNA #3 said Resident #23 did not refuse showers. CNA #3 said Resident #23 liked CNA #3 to provide assistance with showers as she also shaved the resident. The DON and the DOCS were interviewed together on 12/17/24 at 3:46 p.m. The DOCS said there was no documentation in Resident #23's electronic medial record (EMR) that indicated the resident had received a shower from 11/29/24 to 12/13/24. The DON said she would expect Resident #23 to receive two showers each week, or eight showers in a four week period. The DON and the DOCS said they recognized the staff were not documenting showers and were going to develop a plan to provide staff education regarding documentation of showers received. III. Resident #33 A. Resident status Resident #33, age 67, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia, cerebral infarction (stroke), post traumatic stress disorder (PTSD) and depression. The 10/11/24 MDS assessment revealed Resident #33 had moderate cognitive impairments with a BIMS score of 10 out of 15. The resident was independent with oral hygiene and toileting. He required partial to moderate assistance with showering. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #33 was interviewed on 12/19/24 at 2:12 p.m. Resident #33 said he cleaned himself up at the sink in his room. C. Record review Resident #33's care plan, revised 10/30/23, revealed Resident #33's shower preference sheet was updated and Resident #33 preferred to shower three times per week. Review of the shower schedule posted at the nurse's station revealed Resident #33 was scheduled to receive showers every week on Monday, Wednesday and Friday. Resident #33's bathing/showering record from 9/1/24 to 11/30/24 was provided by the DOCS on 12/17/24 at 1:33 p.m. The bathing/shower records provided and the TAR for December 2024 were reviewed from 10/16/24 to 12/16/24. The records revealed the following: Resident #33 refused three showers on 10/28/24, 11/4/24 and 11/18/24. Resident #33 received 11 showers out of 24 opportunities. There was no documentation indicating the resident had received a shower since 11/29/24, indicating the resident had not received a shower in 17 days. -Other than three refusals, review of the resident's bathing records revealed no documentation to indicate why the resident missed his showers or what interventions were attempted for Resident #33's missed showers, particularly since 11/29/24. D. Staff interviews CNA #4 was interviewed on 12/17/24 at 10:28 a.m. CNA #4 said Resident #33 always wanted to take his showers and said she did not think Resident #33 ever refused showers. CNA #4 said Resident #33 was always ready for showers and sometimes waited in the hallway with his shower items. CNA #3 was interviewed on 12/17/24 at 11:00 a.m. CNA #3 said Resident #33 did not refuse showers. CNA #3 said she thought she had helped him shower the previous week. The DON and the DOCS were interviewed together on 12/17/24 at 3:48 p.m. The DOCS said he did not find any documentation for Resident #33's showers from 11/29/24 until 12/16/24. The DON said she would expect Resident #33 to receive 12 showers in a four week period (three per week). The DON said she would expect staff to document every shower provided and every refusal by residents in their EMRs.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20287

Based on observations and interviews, the facility failed to provide a comfortable and homelike environment for 14 out of 65 resident rooms.

Specifically, the facility failed to ensure:

-Residents were provided clean washcloths and hand towels in their rooms on the East and [NAME] units;

-Resident #6's closet was cleaned timely; and,

-The clogged toilet in a resident's bathroom was cleaned timely and appropriately.

Findings include:

I. Facility policy and procedure

The Homelike Environment Policy, revised 2021, was provided by the director of clinical services (DCOS) on 12/17/24 at 6:58 p.m The policy read in pertinent part, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment, personalized room furniture and room arrangements, clean bed and bath linens that are in good condition, pleasant neutral scents, and comfortable sound levels.

II. Failed to ensure residents were provided clean washcloths and hand towels

A. Observations

On 12/11/24 at 3:15 p.m., room [ROOM NUMBER] had no hand towels or washcloths.

On 12/12/24 at 9:44 a.m. room [ROOM NUMBER] had no hand towels or washcloths.

On 12/12/24 9:40 a.m., room [ROOM NUMBER] had no hand towels or washcloths.

On 12/16/24 beginning at 2:12 p.m., the following observations were made:

-room [ROOM NUMBER] had no hand towels or washcloths;

-room [ROOM NUMBER] had no hand towels or washcloths;

-room [ROOM NUMBER] had no hand towels or washcloths;

-room [ROOM NUMBER] had no hand towels or washcloths;

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; and, -room [ROOM NUMBER] had no hand towels or washcloths. On 12/17/24 at 6:25 p.m. the linen closets on the East and [NAME] units contained linen towels. B. Resident group interview The resident group interview was conducted on 12/17/24 at 1:05 p.m. The group consisted of five residents (#115, #28, #4, #16, and #17) who were interviewable based on assessment and facility. The residents said they continued to have concerns about the lack of towels. The residents said linen towels were not available. The residents said the housekeepers would remove the dirty towels and not replace them with clean towels. The residents said there were not enough towels and they had to use paper towels to wash and dry their faces. C. Resident interview Resident #49 was interviewed on 12/16/24 at 2:20 p.m. Resident #49 said he was not offered any towels. He said that he wished he had linen towels available. D. Staff interview The director of nursing (DON) was interviewed on 12/17/24 at 6:10 p.m. The DON said the nursing staff were responsible for passing out towels to the residents. She said towels should be passed out on each shift. She said she was not aware the towels were not being passed out. She said she would correct the issue immediately. The nursing home administrator (NHA) was interviewed on 12/17/24 at 6:19 p.m. The NHA said the facility had recently purchased quite a lot of towels. He said there was no shortage of towels. III. Failed to ensure Resident #6's closet was cleaned appropriately On 12/11/24 at 3:15 p.m., Resident #6's closet had remnants of dried feces on the floor of the closet, on the door and along the wall. A. Resident interview and observation (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 was interviewed on 12/11/24 at 3:15 p.m. Resident #6 said in September 2024 a few months ago she was scheduled for a colonoscopy. She said when she was completing the preparation for the colonoscopy, she got up to go to the bathroom and fell . She said when she fell , feces sprayed all over the floor. She said there continued to be bowel movement on the closet floor and splattered on the wall. She said she had requested it to be cleaned up, however it had not been cleaned. Resident #6's closet had remnants of dried feces on the floor of the closet. There was also dried feces on the door and along the wall. B. Staff interviews The regional director of operations (RDO) was interviewed on 12/18/24 at approximately 2:00 p.m. The RDO said he observed the dried feces on the floor of Resident #6's closet and the wall. He said it would be cleaned immediately. An unidentified houskeeper was interviewed on 12/19/24 at approximately 8:30 a.m. an She said the resident's rooms were cleaned daily. 47151 III. Failure to ensure the clogged toilet in a residents bathroom was cleaned timely and appropriately A. Observation and resident interviews On 12/12/24 the following was observed in Resident #51's room and the East unit: At 9:33 a.m. an unidentified housekeeper exited room [ROOM NUMBER] and placed a wet floor sign in front of the door to the room. After the unidentified housekeeper exited the area, the toilet in the bathroom was observed to have a backup of water approximately an inch from the toilet seat. The water in the toilet was dark brown and contained feces, and toilet paper was visible in a mound on top of the water. A plunger was in the corner of the bathroom with plastic wrapped around the rubber end of the plunger. A resident that resided in room [ROOM NUMBER] said he reported that the toilet was plugged to the housekeeper who cleaned his room. At 11:19 a.m. the toilet in room [ROOM NUMBER] was observed and revealed the same concern as the previous observation (at 9:33 a.m.) At 1:31 p.m. the toilet in room [ROOM NUMBER] was observed and the water had receded to a normal level in the toilet and the toilet paper was no longer visible. The toilet water was dark brown and contained fecal matter. A resident who resided in room [ROOM NUMBER] said a staff member tried to work on the toilet but he was not sure who the staff member was. B. Staff interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance director (MTD) was interviewed on 12/12/24 at 3:10 p.m. The MTD said he had not received training on how to clean bodily fluids so he followed up with the nurse in the east hall where room [ROOM NUMBER] was located. The MTD said he received a work order for a plugged toilet in room [ROOM NUMBER], so he told the nurse in the east hall that there was a toilet that needed to be unplugged. The MTD said the certified nurse aides (CNA) were told to glove up and have a trash bag to unplug the toilet. The MTD said this was the process at the facility for the last four years. Registered nurse (RN) #2 was interviewed on 12/16/24 at 2:25 p.m. RN #2 said the MTD asked her on 12/12/24 where the CNA was working. RN #2 said the MTD told her (RN# 2) the toilet in room [ROOM NUMBER] was clogged and the facility staff had put in a work order for the clogged toilet. RN #2 said the MTD told the nurse go into room [ROOM NUMBER]'s bathroom, reach in the toilet and remove the paper and stool from the toilet. RN #2 said the MTD did not instruct the staff which PPE to use and told RN #2 that the nursing staff were trained on bodily fluids so it was a nurse or CNAs job to unplug the toilet. RN #2 said a CNA unplugged the toilet in room [ROOM NUMBER]. The RDO was interviewed on 12/18/24 at 12:30 p.m. The RDO said after speaking to the facility's regional plant operations support, plunging or unplugging a toilet was something all staff could do. The RDO said if staff were unable to repair a toilet in a timely manner, the residents could use another bathroom in the facility. The RDO said there were plungers in the facility that could be used to plunge the toilets. The RDO said the housekeeping staff could plunge the toilet. The RDO said while the nursing staff was able to plunge a toilet, the preference was the CNA to prioritize resident care as it was a more specialized area, although a CNA could plunge the toilet if needed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to thoroughly investigate allegations of verbal abuse for two (#37 and #21) of five residents reviewed for abuse out of 41 sample residents. Specifically, the facility failed to thoroughly investigate allegations of verbal abuse for Resident #37 and #21. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was received from the nursing home administrator (NHA) on 12/11/24. The policy read in pertinent part, This community does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Verbal abuse is defined as the use of oral, written, or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, regardless of their ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. In addition to an investigation by the police department, the facility conducts an internal investigation. While the investigation is ongoing, the alleged assailant has interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 (five) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. II. Resident #37 A. Resident #37 Resident #37, age less than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included fluid overload, cognitive communication deficit and hypertension. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Thornton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Thornton Pkwy Thornton, CO 80229	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/19/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. She was dependent on staff for activities of daily living (ADL). B. Resident interview Resident #37 was interviewed on 12/12/24 at 9:38 a.m. Resident #37 said Resident #31 yelled at her and scared her. She said it made her feel unsafe. On 12/12/24 at 2:44 p.m. the NHA was informed of Resident #37's report of not feeling safe because Resident #31 yelled at her. C. Record review A complaints concern card, dated 12/12/24, documented that Resident #37 reported she did not feel comfortable/safe with another resident (Resident #31) who yelled at her. The form documented the facility would make sure the two residents did not sit near each other in the dining room. -The complaints form did not include any further documentation to indicate the facility completed an investigation of Resident #37's allegation. -The form failed to include staff interviews, interviews from other residents, or further interviews with Resident #37 or Resident #31. -The facility was unable to provide documentation of an investigation related to Resident #37's allegation of verbal abuse from Resident #31. D. Staff interviews The social services consultant (SSC) was interviewed on 12/16/24 at 11:55 a.m. The SSC said anytime there was an allegation of abuse, an investigation should be completed and interventions put into place to make residents feel safe. The NHA was interviewed on 12/19/24 at 10:09 a.m. The NHA said he spoke with Resident #37 on 12/12/24 about her concern with Resident #31. He said she did not report feeling afraid, but she wanted to be kept separated from Resident #31. He said his interview with Resident #37 constituted an investigation of the allegation. He said based on the findings of his interview with a resident he would determine if the facility needed to complete an investigation of the incident. The NHA said based on what Resident #37 told him when he interviewed her, he did not think the incident needed to be investigated as an allegation of abuse. -The NHA did not provide documentation of his interview with Resident #37 before the survey exit on 12/19/24. E. Facility follow up (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of clinical services (DOCS) provided additional information via email on 12/20/24 at 3:01 p.m. The email documented that, upon notification of a potential concern, the facility had acted timely and interviewed Resident #37. The email indicated the interview conducted by the NHA was completed and at no time did Resident #37 claim to have been the victim of abuse. The concern was transcribed to a grievance form and the resident signed to express satisfaction with the proposed resolution to the concern. -However, the facility did not provide documentation of the NHA's interview with Resident #37 or documentation of further investigation into the incident. 47960 III. Resident #21 A. Resident status Resident #21, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the December 2024 CPO, diagnoses included congestive heart failure, major depressive disorder and anxiety disorder. The 11/19/24 MDS assessment revealed Resident #21 was cognitively intact with a BIMS score of 13 out of 15. He was independent with personal hygiene, dressing and eating. The assessment documented the resident did not exhibit any behavioral symptoms. B. Observations On 12/12/24 at 3:09 p.m. Resident #21 requested his scheduled Lyrica medication (a prescription medication used to treat nerve and muscle pain). Resident #21 was very upset and yelled, This place does not care, I would rather die than be here. At 3:13 p.m., Resident #21 left his room in his wheelchair to go outside to smoke. As he approached the outside door, Resident #44 got in front of him and told him he looked guilty. Resident #21 began yelling at Resident #44 and told her to shut up and get out of the way. Resident #21 was very angry and told Resident #44 if he wanted her opinion he would give it to her. Resident #21 moved past Resident #44 and went outside. Resident #44 followed Resident #21 outside and continued talking to him. At 3:14 p.m., Resident #21 got more angry, moved closer to Resident #44 and waved his hands in front of Resident #44's face aggressively. At 3:16 p.m. registered nurse (RN) #1 was summoned after yelling for her attention for two minutes. RN #1 went outside to address the situation between Resident #21 and Resident #44. At 3:18 p.m., Resident #21 returned inside. At 3:35 p.m. the NHA was informed of the incident between Resident #21 and Resident #44. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review A review of Resident #21's electronic medical record (EMR) on 12/19/24 did not reveal any documentation of the reported incident between Resident #21 and Resident #44 reported to RN #1 and the NHA on 12/12/24. The facility investigation was requested on 12/18/24 and again on 12/19/24. The NHA provided a grievance form that he completed on 12/12/24. The grievance form documented Resident #21 was agitated but did not have any concerns. The grievance form did not include any interviews with Resident #44, staff or other residents. D. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 12/12/24 at 3:40 p.m. CNA #2 said when residents were agitated and aggressive towards another resident, the staff attempted to separate the residents and redirect them. She said it was also the staff's responsibility to report the incidents to the NHA. CNA #2 said she was not aware of any incident that occurred between Resident #21 and Resident #44 on 12/12/24. The SSC was interviewed on 12/17/24 at 11:47 a.m. The SSC said any time an allegation of any type of abuse was reported, an investigation should be done. She said the investigation should include interviews with the parties involved, staff and witnesses. The SSC said once the interviews were completed, the facility should follow up with interventions, education with staff and anything else that would help the residents feel safe. The NHA was interviewed on 12/19/24 at 9:57 a.m. The NHA said any time allegations were made of verbal or physical abuse, they should be investigated. He said the residents involved should be interviewed to determine if the investigation should proceed. The NHA said he, or his designee, were responsible for investigating all allegations. The NHA said he interviewed Resident #21 and Resident #44 and neither resident expressed any concerns. He said he followed up a couple of days after the incident and both residents reported that they felt uncomfortable. The NHA said he reviewed reports for each resident for 24 hours after the incident to look for changes in the residents and did not find anything that would have increased either residents' agitation on the day of the incident. -However, the facility did not provide documentation of the NHA's interview with Resident #21 or Resident #44 or documentation of further investigation into the incident.

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F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on interviews and record review, the facility failed to ensure residents were permitted to remain in the facility and not transfer or discharge for one (#216) of three residents out of 41 sample residents.

Specifically, the facility failed to provide Resident #216 with an appropriate discharge process.

Findings include:

I. Facility policy and procedure

The Discharge Planning policy, dated 2/29/24 was provided by the director of clinical services (DOCS) on 12/19/24 at 1:34 p.m. It read in pertinent part, The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals. This will include identifying ways for residents to be active participants and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identity changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications.The results of the evaluation and the final discharge plan will be discussed with the resident or the resident's representative. All relevant information will be provided in a discharge summary to avoid delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living arrangement. If discharge to community is determined to not be feasible, the facility will document who made the determination and why. Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge.

II. Resident status

Resident #216, under the age of 65, was admitted on [DATE] and discharged on [DATE] to the emergency department. According to the October 2024 computerized physician orders (CPO), diagnoses included diverticulitis (inflamed pouches in the large intestine), frontal lobe deficit following cerebral infarction (disrupted blood flow to the brain), hemiplegia and hemiparesis, major depressive disorder, anxiety disorder and acute kidney failure.

The 10/19/24 minimum data set (MDS) assessment documented the resident required set up assistance with eating and was independent with all other activities of daily living (ADL).

The assessment documented the resident had physical and verbal behaviors directed at others.

The assessment documented there was no active discharge planning in place.

A review of the resident's electronic medical record (EMR) revealed on 8/20/24 the resident was documented as moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Record review The 30-day notice of involuntary discharge, dated 9/24/24, was provided by the DOCS on 12/18/24. The discharge notification documented the letter informed Resident #216 the facility issued an involuntary discharge in the interest of Resident #216's safety and welfare as well as the safety and welfare of other residents who resided within the facility. Resident #216 was to be discharged from the facility on 10/24/24. A review of Resident #216's EMR documented in a 10/19/24 provider note at 2:19 p.m. that a nurse called to report the facility was immediately discharging Resident #216 from the facility as he assaulted a staff member who was injured and the nurse reported the resident was given a final warning 30 days ago (9/24/24) for violent behavior. The nurse on duty requested to send Resident #216 with his medications. A review of Resident #216's EMR revealed a progress note written on 10/19/24 at 4:50 p.m. that Resident #216 left the facility at 4:30 p.m. with staff transportation to a local hospital. Resident #216 took his belongings with him, which included: wallet, phone, phone charger, hat, slippers, pictures and cross necklaces. The emergency department (ED) provider notes, dated 10/19/24, documented Resident #216 was apparently hostile with his care facility so he was not allowed back that night (10/19/24). The ED had anticipated Resident #216 was to be transferred back to his long-term care facility, however the facility had refused to take the resident back because of his behavior. -However, a review of Resident #216's EMR failed to reveal documentation which indicated the resident had been provided education related to his immediate discharge or that the resident understood his immediate discharge from the facility. IV. Staff interviews The regional director of operations (RDO) was interviewed on 12/19/24 at 10:30 a.m. The RDO said Resident #216 had fallen on 10/19/24 and initially refused to go to the emergency department and returned to his room. The RDO said while Resident #216 was in his room, the facility management team had a call to discuss Resident #216. The RDO said the facility wanted to ensure that Resident #216 received proper care because the resident took coumadin (a blood thinner) and had fallen. The RDO said the facility determined, because of the numerous previous conversations with the resident regarding his behavior, the facility needed to figure out an immediate discharge because Resident #216 was putting other residents at risk. The RDO said Resident #216 agreed later the same day (10/19/24) to be sent to the hospital to be assessed. The RDO said because the manager on duty was involved in an occurrence earlier in the day with Resident #216 where he assaulted a staff member, the facility had the charge nurse on duty discuss Resident #216's discharge with the emergency department. The RDO said any manager on duty could and should document conversations and refusals of care in the resident's EMR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital for one (#216) of three residents reviewed for discharge out of 41 sample residents. Specifically, the facility failed to reassess Resident #216's status at the time the resident sought to return to the facility after a facility-initiated transfer to the hospital, and directed the hospital that the resident was not allowed to return to the facility. Findings include: I. Facility policy and procedure The Discharge Planning policy, dated 2/29/24 was provided by the director of clinical services (DOCS) on 12/19/24 at 1:34 p.m. It read in pertinent part, The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals. This will include identifying ways for residents to be active participants and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identity changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications.The results of the evaluation and the final discharge plan will be discussed with the resident or the resident's representative. All relevant information will be provided in a discharge summary to avoid delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living arrangement. If discharge to community is determined to not be feasible, the facility will document who made the determination and why. Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge. II. Resident status Resident #216, under the age of 65, was admitted on [DATE] and discharged on [DATE] to the emergency department. According to the October 2024 computerized physician orders (CPO), diagnoses included diverticulitis (inflamed pouches in the large intestine), frontal lobe deficit following cerebral infarction (disrupted blood flow to the brain), hemiplegia and hemiparesis, major depressive disorder, anxiety disorder and acute kidney failure. The 10/19/24 minimum data set (MDS) assessment documented the resident required set up assistance with eating and was independent with all other activities of daily living (ADLs). The assessment documented the resident did not have an active discharge plan. The assessment documented the resident had physical and verbal behaviors directed at others. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's electronic medical record (EMR) documented on 8/20/24 the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. III. Record review A review of Resident #216's EMR revealed a progress note written on 10/19/24 at 4:50 p.m. that Resident #216 left the facility at 4:30 p.m. with staff transportation to a local hospital. Resident #216 took his belongings with him, which included: wallet, phone, phone charger, hat, slippers, pictures and cross necklaces. The emergency department (ED) provider notes, dated 10/19/24, documented Resident #216 was apparently hostile with his care facility so he was not allowed back that night (10/19/24). The ED had anticipated Resident #216 was to be transferred back to his long-term care facility, however the facility had refused the resident because of his behavior. -However, review of Resident #216's EMR revealed there was no documentation to indicate the facility had reassessed the resident after his transfer to the ED to determine if the resident was able to return to the facility. -There was no documentation in Resident #216's EMR to indicate what needs the facility could not meet after the resident's transfer to the ED. IV. Staff interviews The regional director of operations (RDO) was interviewed on 12/19/24 at 10:30 a.m. The RDO said Resident #216 had fallen on 10/19/24 and initially refused to go to the emergency department and returned to his room. The RDO said while Resident #216 was in his room, the facility management team had a call to discuss Resident #216. The RDO said the facility wanted to ensure that Resident #216 received proper care because the resident took coumadin (a blood thinner) and had fallen. The RDO said the facility determined, because of the numerous previous conversations with the resident regarding his behavior, the facility needed to figure out an immediate discharge because Resident #216 was putting other residents at risk. The RDO said Resident #216 agreed later the same day (10/19/24) to be sent to the hospital to be assessed. The RDO said because the manager on duty was involved in an occurrence earlier in the day with Resident #216 where he assaulted a staff member, the facility had the charge nurse on duty discuss Resident #216's discharge with the emergency department. The RDO said any manager on duty could and should document conversations and refusals of care in the resident's EMR.

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to ensure a discharge summary was in place for one (#64) out of four sample residents reviewed for discharge out of 41 sample residents. Specifically, the facility failed to ensure the discharge summary included a recapitulation of the resident's stay, a final summary of the resident's status and recapitulation of the residents stay at the facility for Resident #64. Findings include: I. Facility policy and procedure The Discharge Summary and Plan last revised October 2022 was provided by the director of clinical services (DOCS) on 12/19/24.The policy read in percent part, When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. II. Resident #64 A. Resident status Resident #64, age less than 65, was admitted on [DATE] and discharged home with family on 10/11/24. According to the December 2024 computerized physician orders (CPO) diagnoses included congestive heart failure, pulmonary hypertension, severe protein calorie malnutrition and psychoactive substance abuse. The 8/20/24 minimum data set (MDS) had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. The MDS coded the resident had inattention and disorganized thinking. The resident was dependent on staff for personal hygiene. -The discharge planning review dated 8/16/24 documented the resident planned on staying long-term in the facility. B. Record review The 10/11/24 progress note documented the nurse practitioner was notified and advised the nurse that the resident could have a four day pass, but advised that the resident needed to obtain his medications. The nurse spoke to the resident and his emergency contact on the phone. The nurse advised the resident to come back to the facility to obtain his medications while he was out on pass. The nurse explained the risk of being without his meditations for four days. The resident said he was going to try and pick up the medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 10/11/24 nurse practitioner note documented in the progress note showed the provider was notified the resident left the facility to see his mother in the hospital. The note further documented the resident was not returning for four days. The nurse educated the resident to return to the facility to collect his chronic medications. -Review of Resident #64's electronic medical record (EMR) failed to show documentation which indicated a final summary of the resident's status and recapitulation of the residents stay. C. Staff interviews RN #1 was interviewed on 12/19/24 at 10:30 a.m. RN #1 said she was the nurse on duty when Resident #64 left the facility by choice to see his mother who had suffered a stroke RN #1 said she provided the resident with a one day supply of his medications. She said the resident was on Eliquis (blood thinner), which was an important medication he needed. She said he then called and said he would be out for four more days and she said his medications were ordered by the physician. RN #1 said the resident's mother picked up the medications from the facility. She said the resident did not return to the facility. She said could not locate that a discharge summary was completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48458

Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for two (#32 and #48) of eight residents reviewed out of 41 sample residents.

Specifically, the facility failed to:

-Ensure Resident #32, who was dependent on staff for bathing, received her scheduled showers.

-Ensure Resident #48, who was blind, received meal assistance.

Findings include:

I. Facility policy and procedure

The Bath, Shower/Tub policy, revised February 2018, was provided by the director of clinical services (DOCS) on 12/17/24 at 6:58 p.m. The policy read in pertinent part,

The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The date and time the shower/tub bath was performed, the name and title of the individual(s) who assisted the resident, all assessment data, if the resident refused the shower/tub bath, the reason(s) why and the intervention taken, the signature and title of the person recording the data. Notify the supervisor if the resident refuses the shower/tub bath.

II. Resident #32

A. Resident status

Resident #32, age less than 65, was admitted on [DATE]. According to the December 2024 computerized physician's orders (CPO), diagnoses included dementia, kidney disease, anxiety, cerebral aneurysm (bulge or ballooning of a blood vessel in the brain) and blindness.

The 11/5/24 minimum data set (MDS) assessment revealed Resident #32 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required set-up assistance from staff with oral hygiene and was dependent for toileting and showering/bathing.

B. Resident interview and observation

Resident #32 was interviewed on 12/11/24 at 10:23 a.m. Her hair was disheveled and there was a large amount of tangled hair on the back of her head, approximately two inch by two inch area. The resident had body odor. Resident #32 said she had knots in her hair and had not showered in at least a week. Resident #32 said the staff had to use a lift to assist her with showering. Resident #32 said the staff frequently missed providing her showers.

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	065193	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review Resident #32's care plan, revised 10/30/24, revealed Resident #32's shower preference sheet had been updated and she was dependent on one staff to provide showers, and one to two staff to assist with personal hygiene and oral care. Review of the shower schedule posted at the nurse's station revealed Resident #32 was scheduled to receive showers every week on Monday and Friday. Resident #32's bathing/showering record from 9/1/24 to 11/30/24 was provided by the DOCS on 12/17/24 at 1:33 p.m. The bathing/shower records provided and the treatment administration record (TAR) for December 2024 were reviewed from 10/16/24 to 12/16/24. The records revealed the following: Resident #32 refused one shower on 12/13/24 (during the survey). -There was no other documentation to indicate Resident #23 had refused other scheduled showers. Resident #32 received 13 showers out of 16 opportunities. There was no documentation indicated the resident had received a shower since 11/29/24, indicating the resident had not received a shower in 17 days -Other than the documented refusal on 12/13/24, review of Resident #32's bathing records revealed no documentation to indicate why the resident missed her showers or what interventions were attempted for Resident #32's missed showers. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 12/17/24 at 9:58 a.m. LPN #1 said Resident #32 was very cooperative and did not refuse any care, including bathing. Certified nurse aide (CNA) #4 was interviewed on 12/17/24 at 10:14 a.m. CNA #4 said Resident #32 was dependent on staff and the staff used a lift to provide her showers. CNA #4 said Resident #32 did not refuse showers. CNA #4 said there was often one day per week when there were not enough staff present to complete all of the residents' showers. CNA #4 said when a resident did not receive a shower, staff tried to provide the shower the following day. CNA #4 said she reported to the nurse when a resident did not receive a shower. CNA #3 was interviewed on 12/17/24 at 10:52 a.m. CNA #3 said Resident #32 did not usually refuse to shower, however, CNA #3 said Resident #32 told her that she refused to shower on 12/16/24 because CNA #3 was not working that day. The director of nursing (DON) and the DOCS were interviewed together on 12/17/24 at 3:39 p.m. The DOCS said Resident #32's shower record contained multiple entries of not applicable and he did not understand why this was documented. The DOCS said there were no showers documented for Resident #32 between 11/29/24 and 12/16/24. The DOCS said there were no additional documented shower refusals. The DON said she would expect Resident #32 to receive showers as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20287 III. Resident #48 A. Resident status Resident #48, age 68, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified macular degeneration (decreased vision), dysphagia, depression and cognitive communication deficit. The 9/27/24 MDS assessment showed the resident had severe cognitive impairments with a BIMS score of three out of 15. The resident had moderately impaired vision. The resident was independent in eating. B. Resident interview Resident #48 was interviewed on 12/11/24 at approximately 3:00 p.m. Resident #48 said she was legally blind and she could only see shadows. C. Observations During a continuous observation of the dinner meal on 12/12/24, beginning at 5:09 p.m. and ending at 5:11 p. m. the following was observed: At 5:09 p.m.,Resident #48 received her meal. An unidentified CNA served the resident her meal. The unidentified CNA told the resident what was on her plate, but did not tell her where the food was located on the plate. Resident #48 was putting her hands over the plate attempting to locate the fish sandwich. At 5:11 p.m., the resident said out loud, I do not know where my food is but I will try to eat it. During a continuous observation of the dinner meal on 12/16/24, beginning at 5:06 p.m. and ending at 5:08 p. m., the following was observed: dinner meal At 5:06 p.m., the resident received her meal. CNA #5 told the resident what was on her plate, but not the location of the food on the plate. At 5:08 p.m., the resident was provided a packet of salt and pepper with her meal. The resident opened the salt packet. She did not know which each packet was, so she held the packet over her food and put her finger into the salt that was pouring out to identify if it was salt or pepper. When she received her meal and the salt and pepper packets the staff did not identify. D. Record review The care plan, revised on 5/9/24, identified the resident had impaired visual function related to cataracts. Pertinent approaches included to tell the resident where her food items were located and to be consistent. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Staff interviews CNA #8 was interviewed on 12/18/24 at 5:00 p.m.CNA #8 said Resident #48 was blind and that she needed to know the location of her food. She said she was able to eat independently, but needed to be told where the food was located. The assistant director of nursing (ADON) was interviewed on 12/18/24 at 5:29 p.m. The ADON said Resident #48 was legally blind. She said the staff needed to tell the resident where her food was on her plate, not just what was on the plate. She said she would provide training to the staff.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20287

Based on record review and interviews, the facility failed to ensure one (#24) of two residents out of 41 sample residents received treatment and care in accordance with professional standards of practice.

Specifically, the facility failed to ensure treatment was provided to Resident #24's skin injury in a timely manner.

Findings include:

I. Resident #24

A. Resident status

Resident #24, age less than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes, history of other venous thrombosis (a condition where a blood clot, or thrombus, forms in a vein and blocks blood flow) and embolism (occurs when a blockage, called an embolus, lodges in a blood vessel and prevents blood from flowing).

The 11/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15 The resident was independent with activities of daily living (ADL).

B. Observations

On 12/11/24 at 9:46 a.m. Resident #24 was observed to have his pant leg pulled up. He had a fast food napkin stuck to his left shin which was bleeding. Resident #24 said he had injured his leg by falling at his daughter's house on 12/7/24.

On 12/12/24 at 2:32 p.m. Resident #24's leg was observed with registered nurse (RN) #1. RN #1 measured the resident's skin tear on his left shin. She asked the resident what happened and Resident #24 said he fell at his daughter's house on Saturday (12/7/24). RN #1 cleaned and applied a dressing to the resident's skin tear.

C. Record review

Review of Resident #24's skin daily skin observation forms from 12/7/24 to 12/12/24 documented the resident's skin was monitored daily from 12/7/24 through 12/12/24 and there were no concerns.

-However, observations on 12/11/24 and 12/12/24 revealed Resident #42 had a skin tear on his left shin which the resident reported he obtained from a fall at his daughter's house on 12/7/24 (see observations and resident interview above).

-Review of Resident #24's electronic medical record (EMR) failed to reveal the resident's left shin skin tear was identified by the facility and was treated/monitored prior to 12/12/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #24's EMR failed to reveal the resident's physician was notified of the skin tear An undated wound education was received from the director of nursing (DON) on 12/12/24 at 3:09 p.m. The education documented that when a new area of skin breakdown on a resident was identified, it was important that the nurse was notified immediately. It was the responsibility of the nurse to notify the physician, initiate a risk management occurrence and obtain treatment orders. The education included that appropriate documentation of the skin concern was required. II. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 12/12/24 at 2:20 p.m. LPN #1 said she was not aware of Resident #24's skin tear on his leg. She said she did go into the resident's room yesterday (12/11/24) to administer medications, however, she said she did not notice the resident's leg and the resident did not tell her about his skin tear. RN #1 was interviewed on 12/12/24 at 2:50 p.m. RN #1 said she was not aware of Resident #24's left leg skin tear. She said she had been off for the past few days. RN #1 said she notified the physician and received orders to treat the skin tear (on 12/12/24).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observation, record review and interviews, the facility failed to ensure proper treatment and services to maintain vision abilities for one (#23) of seven residents reviewed for vision services out of 41 sample residents. Specifically, the facility failed to ensure Resident #23's new glasses were obtained in a timely manner. Findings include: I. Resident #23 A. Resident status Resident #23, age 69, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis or weakness on one side of the body), peripheral vascular disease (disorder of the blood vessels), mood disorder and chronic obstructive pulmonary (lung) disease. The 9/26/24 minimum data set (MDS) assessment revealed Resident #23 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent with eating and dressing and required supervision or substantial assistance with most other activities of daily living (ADL). The MDS assessment documented the resident had adequate vision with eye glasses. B. Resident observation and interview Resident #23 was interviewed on 12/11/24 at 12:30 p.m. Resident #23 was not wearing eyeglasses. Resident #23 said he had seen an eye doctor, but the facility had not assisted him with getting new eyeglasses. Resident #23 said he was told the eyeglasses were ordered after his appointment a few months ago, but he had not received them. C. Record review The 10/21/24 eye consult office visit revealed Resident #23 had an eye exam. The note had a new prescription for eyeglasses included with a note to deliver glasses two weeks from receipt of payment. The prescription was signed by the physician on 10/21/24. -Review of Resident #23's electronic medical record (EMR) did not reveal documentation to indicate the resident had received his new eye glasses II. Staff interviews (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services consultant (SSC) was interviewed on 12/17/24 at 12:01 p.m. The SSC said she would review Resident #23's EMR to check if the resident had received his new glasses. The SSC said she expected eyeglasses to be ordered within one month of an issued prescription. Certified nurse aide (CNA) #3 was interviewed on 12/17/24 at 10:59 a.m. CNA #3 said she had not seen Resident #23 with glasses on before and she did not know if he needed them. The SSC was interviewed a second time on 12/17/24 at 4:42 p.m. The SSC said Resident #23 had received a prescription for new eyeglasses when he saw the eye doctor on 10/21/24, however, she said the facility did not initiate a request for funding the purchase of Resident #23's eyeglasses until 12/13/24 (during the survey). The SSC said the request for the funding process should have been initiated shortly after the eye exam on 10/21/24. The SSC said the facility had not yet ordered the eyeglasses as of 12/13/24. She said the facility would order Resident #23's eyeglasses immediately.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observation, interview and record review the facility failed to provide adequate supervision during use of assistive devices to keep residents free from safety hazards for three (#9, #26 and #24) of seven residents out of 41 sample residents. Specifically, the facility failed to: -Ensure care planned fall interventions were utilized consistently for Resident #9; -Ensure foot pedals were attached to Resident #9 and Resident #26's wheelchairs when facility staff were pushing the residents in their wheelchairs; -Ensure Resident #26 was transferred appropriately from her chair to her wheelchair using a gait belt (a device used to help prevent falls); and, -Ensure Resident #24 was assessed appropriately for safe smoking. Findings include: II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included acute kidney failure, history of falling and dementia. The 9/20/24 minimum data set (MDS) assessment revealed the resident had both short term and long term memory impairments. The resident had severely impaired daily decision making skills. The resident was dependent on staff for activities of daily living (ADL). The MDS assessment indicated the resident had not experienced any recent falls. B. Failure to ensure care planned fall interventions were utilized consistently 1. Facility policy and procedure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Fall Management policy, dated 2/29/24, was provided by the director of clinical services (DOCS) on 12/17/24 at 6:58 p.m. It read in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. Research has shown that structured fall reduction programs can substantially reduce the rate of falls and fall related injuries in nursing facilities; however falls may likely occur. Risk factors that are internal to the resident included the resident's physical health and functional status. External factors include medication side effects, the use of appliances, and environmental conditions. To be effective, a fall reduction program is characterized by four components: Fall risk evaluation, care planning and implementation of interventions, ongoing evaluation process and a commitment by caregivers to make it work. Each resident will be reevaluated quarterly, annually and when a significant change occurs. Individualized care plan interventions will be implemented for residents found to be at high risk for falls. Interventions are to be re-evaluated when a resident falls for efficacy. Document in the resident's electronic medical record (EMR) the resident's response to interventions and revise the interventions if they are not successful. Monthly the quality assurance and performance improvement (QAPI) committee will review residents with falls for updated interventions and/or recommendations. 2. Observations On 12/12/24 at 10:22 a.m. Resident #9 was lying in bed. There was no fall mat beside the bed. On 12/12/24 at 2:30 p.m. Resident #9 was lying in bed. There was no fall mat beside the bed. On 12/16/24 at 10:15 a.m. Resident #9 was lying in bed. There was no fall mat beside the bed. On 12/16/24 at 3:35 p.m. Resident #9 was lying in bed. There was no fall mat beside the bed. On 12/17/24 10:36 a.m. licensed practical nurse (LPN) #1 observed Resident #9 was in bed with no fall mat beside the resident's bed. LPN #1 looked in Resident #9's room and was unable to find the fall mat that was supposed to be beside the resident's bed when the resident was in bed. 3. Record review Review of Resident #9's December 2024 CPO revealed the resident had a physician's order to have a fall mat on the floor next to her bed while she was in the bed, revised 12/16/24 (during the survey). The care plan, initiated 9/9/24, identified Resident #9 was at high risk for falls. Pertinent interventions were to have a fall mat to the side of the bed when she was lying down. 4. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 12/17/24 at 10:36 a.m. LPN #1 reviewed Resident #9's care plan and confirmed the resident was to have a fall mat next to the bed when she was lying in bed. LPN #1 said the resident had not had any recent falls, however, she said she was a contracted agency nurse who had only been at the facility for three months. After confirming the fall mat was not beside Resident #9's bed, LPN #1 said she would locate a fall mat for the resident. The director of nursing (DON) was interviewed on 12/17/24 at 6:10 p.m. The DON said Resident #9 was on hospice services and was at risk for falls. She said the fall mats were available in the facility. She said she would ensure Resident #9 received the fall mat. C. Failure to have wheelchair foot pedals attached during transport 1. Observations On 12/12/24 at 11:00 a.m. Resident #9 was being pushed into the dining room in her wheelchair by an unidentified staff member. There were no foot pedals attached to her wheelchair, which caused the resident to hold her feet up off the floor. On 12/12/24 at 4:23 p.m. Resident #9 was being pushed to the dining room in her wheelchair by certified nurse aide (CNA) #11. The resident did not have any foot pedals on her wheelchair, which caused the resident's feet to dangle. 2. Record review The care plan, initiated 9/9/24, identified the resident was a high risk for falls. Pertinent interventions were to ensure the resident had proper footwear when mobilizing in her wheelchair. -The care plan did not include an intervention to ensure Resident #9's foot pedals were in place when transporting the resident in her wheelchair in order to prevent potential falls. III. Resident #26 A. Resident status Resident #26, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included atherosclerotic heart disease, hypertension, dementia and cognitive communication deficit. The 10/23/24 MDS assessment revealed the resident had both short term and long term memory impairments. The resident had severely impaired daily decision making skills. The resident was dependent on staff for ADLs. B. Failure to have wheelchair foot pedals attached during transport 1. Observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 4:23 p.m. Resident #26 was being pushed to the dining room in her wheelchair by CNA #5. The resident did not have any foot pedals on her chair which caused the resident's feet to dangle. On 12/16/24 at 8:57 a.m. Resident #26 was being pushed to her room in her wheelchair by CNA #6. The resident did not have any foot pedals on her wheelchair which caused the resident's feet to dangle. On 12/16/24 at 11:26 a.m. Resident #26 was being pushed into the dining room in her wheelchair by an unidentified staff member. There were no foot pedals on her wheelchair which caused the resident's feet to dangle. On 12/17/24 at 4:32 p.m. Resident #26 was being pushed to the dining room in her wheelchair by CNA #5. The resident did not have any foot pedals on her chair which caused the resident's feet to dangle. 2. Record review The care plan, revised 7/30/24, identified Resident #26 was at risk for falls related to dementia, unsteady gait and history of falls. Pertinent interventions were to ensure the resident had proper footwear when mobilizing in her wheelchair. -The care plan did not include an intervention to ensure Resident #26's foot pedals were in place in order to prevent potential falls when the resident was being pushed in her wheelchair. The fall risk assessment dated [DATE] revealed Resident #26 as a high fall risk. 3. Staff interview The DON was interviewed on 12/17/24 at 6:10 p.m. The DON said Resident #9 and Resident #26's feet should not have been dangling while they were being transported in their wheelchairs (see Resident #9 and Resident #26's observations above). She said foot pedals needed to be used and all residents' wheelchairs should have the foot pedals. The DON said staff should not push a resident in their wheelchair if they had to hold their feet up. She said there was no system in place as to where the foot pedals were kept so they were easily accessible to staff for the transportation of residents. C. Failure to ensure resident was transferred appropriately from her chair to her wheelchair using a gait belt 1. Facility policy and procedure The Safe Lifting and Movement of Residents policy, revised July 2017, was received from the DOCS on 12/18/24. The policy read in pertinent part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts and lateral boards) and mechanical lifting devices. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observations On 12/12/24 at 11:56 a.m. Resident #26 was assisted from her stationary chair to her wheelchair by an unidentified CNA. The CNA held both of the resident's hands while she pulled her to a standing position. The resident then pivoted to the wheelchair. -The CNA failed to use a gait belt on Resident #26 during the transfer. On 12/12/24 at 4:26 p.m. Resident #26 was assisted from her stationary chair to her wheelchair by CNA #5. CNA #5 held both of the resident's hands while she pulled her to a standing position. The resident then pivoted to the wheelchair. -CNA #5 failed to use a gait belt on Resident #26 during the transfer. On 12/17/24 at 4:29 p.m. Resident #26 was assisted from her stationary chair to her wheelchair by CNA #5. CNA #5 held both of the resident's hands while she pulled her to a standing position. The resident then pivoted to the wheelchair. -CNA #5 failed to use a gait belt on Resident #26 during the transfer. 3. Record review The care plan, updated 10/29/24, identified Resident #26 was at risk for falls related to unsteady gait. Pertinent interventions included transferring the resident with supervision to substantial assistance. -The care plan failed to include the use of a gait belt during transfer. 4. Staff interviews The DON was interviewed on 12/17/24 at 6:10 p.m. The DON said when a resident was assisted to a standing position, a gait belt was to always be used for the safety of the resident. She said the nursing staff were trained to use the gait belt, however, she was not sure when the last training related to gait belt use was. The occupational therapist (OT) was interviewed on 12/18/24 at 4:53 p.m. The OT said a gait belt should be used when assisting a resident to a standing position. She said the trunk (upper body) had the best control and pulling on a resident's arms was not good, as there were a lot of muscles which could get injured. IV. Resident #24 A. Resident status Resident #24, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included type 2 diabetes, history of other venous thrombosis (a condition where a blood clot, or thrombus, forms in a vein and blocks blood flow) and embolism (occurs when a blockage, called an embolus, lodges in a blood vessel and prevents blood from flowing). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/13/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent in ADLs B. Failure to ensure the resident was assessed for safe smoking 1. Facility policy and procedure The Traditional Tobacco and Electronic Smoking Device Policy, revised on 5/10/23, was provided by the DOCS on 12/19/24 at 1:03 p.m. It read in pertinent part, All residents who smoke or desire to smoke will be appropriately assessed to determine if the resident requires supervision and protective equipment during smoking. The assessment tool used for this purpose is the (name of the electronic medical record) Smoking Risk Assessment. Smoking assessment and potential restrictions shall be completed upon admission, quarterly at the time of unsafe smoking behavior or suspicion of smoking in an undesignated area or upon any change of condition, which would impact the residents ability to smoke and or smoke safely. 2. Resident observation and interview On 12/11/24 at 9:49 a.m. Resident #24 was sitting on his bed near his bedside table. There was black ash on the table. The resident's room and the resident smelled of cigarette smoke. Resident #24 said he smoked cigarettes and that he was independent with smoking and could go out to smoke whenever he wished. 3. Record review The care plan, revised 8/19/24, identified Resident #24 was an independent unsupervised smoker. Pertinent interventions included instructing and informing the resident about the facility policy on smoking, locations, times and safety concerns, monitoring the resident for any unsafe smoking practices and observing the resident's clothing and skin for signs of cigarette burns. The 9/23/24 progress note documented Resident #24 continued with his normal daily habit of smoking outside. The 11/23/24 progress note documented Resident #24 was observed going into the [NAME] charting room, grabbing another resident's box containing cigarettes, putting the other resident's box of cigarettes into his pants and walking out of the nurses station. The nurse and the manager on duty went into Resident #24's room and requested the box back. The resident gave the cigarettes back to the nurse. The 12/5/24 psychological follow up note documented Resident #24 had a history of smoking cigarettes in his room. Review of Resident #24's smoking assessments revealed the following: The 5/3/24 smoking risk evaluation documented the resident was safe and independent with smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/13/24 smoking risk evaluation documented the resident did not smoke cigarettes. The evaluation form documented the resident said he did not currently have any cigarettes to smoke. The 12/16/24 progress note documented the resident was observed smoking in his room. Resident #24 denied smoking in his room and denied having cigarettes or lighters. The 12/18/24 smoking risk evaluation (completed during the survey) documented Resident #24 did not smoke only in designated areas and did not follow the smoking rules. The evaluation conclusion was the resident was supervised while smoking. 4. Staff interviews The social services consultant (SSC) was interviewed on 12/17/24 at 11:53 a.m. The SSC said the social worker for the facility was out of the facility. The SSC said she was not familiar with Resident #24 but would review the resident's records for the smoking assessment. The DON was interviewed on 12/17/24 at 6:10 p.m. The DON said the smoking evaluation was to be completed when the resident was admitted and on a quarterly basis or change of condition. The DOCS was interviewed on 12/19/24 at approximately 12:00 p.m. The DOCS said the DON was completing an assessment on the resident. He said he did not understand how the resident was not assessed for smoking.

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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** 48458 Based on observations, record review and interviews, the facility failed to ensure residents were free from significant medication errors for two (#6 and #44) of six residents reviewed for medication errors out of 41 sample residents. Specifically, the facility failed to: -Order and administer the correct medication (hydroxyzine) for Resident #6's itching, and not the incorrect medication (hydralazine), for high blood pressure. -Ensure Resident #44 did not receive excessive dosage of acetaminophen. Finding include: I. Failed to ensure the correct medication was ordered and administered A. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed., E.[NAME], St. Louis Missouri, pp. 606-607. 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?: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Institute for Safe Medication Practices (ISMP), revised 2024, retrieved on 12/23/24 from: https://www.consumermedsafety.org/safety-articles/one-drug-pair-name-that-often-results-in-confusion, There Were Often Medication Error Reports That Result From Confusion With Drug Names That Look or Sound Alike. One look-alike and sound-alike pair that often results in confusion is hydralazine and hydroxyzine. Hydralazine is used to treat high blood pressure. Hydroxyzine is an antihistamine used in the treatment of allergic reactions such as itching, rash, hives, sneezing and runny nose. Hydroxyzine is also used to treat anxiety, difficulty sleeping and nausea. Contributing factors leading to these frequent mix-ups are: The first four letters of their names are identical, they are frequently stored next to one another on pharmacy shelves, they are listed alongside one another on computer screens and they have similar dosage strengths (10,25,50 and 100 mg). B. Facility policy and procedure The Medication Administration policy, revised 2/29/24, was provided by the director of clinical services (DOCS) on 12/17/24 at 9:39 a.m. It read in pertinent part, Medications are administered in accordance with written orders of the attending physician or physician extender. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the resident's current diagnosis or condition, contact the physician for clarification prior to the administration of the medication. Document the interaction with the physician in the nursing progress notes and elsewhere in the medical record, as appropriate. C. Resident #6 1. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris (heart disease), insomnia (difficulty sleeping), type 2 diabetes and dependence on oxygen. The 10/29/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required substantial assistance with personal hygiene. 2. Resident interview Resident #6 was interviewed on 12/11/24 at 3:23 p.m. Resident #6 said a certified nurse aide with medication authority (CNA-Med) tried to give her the wrong medication recently. She said she looked at the pill cup and said this is not right. She said that she told the CNA-Med she would not take the medication. Resident #6 said the facility later provided the correct anti-itch medicine. Resident #6 was interviewed a second time on 12/18/24 at 10:00 a.m. The resident said she was given the wrong medication. She said that she thought she took the incorrect medication once and she knew that she caught the error on the last attempt at administration. 3. Record review (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The October 2024 CPO revealed a physician's order for hydroxyzine, 25 milligrams (mg) by mouth every 12 hours as needed for itching, ordered on 10/1/24 and discontinued on 11/7/24. The November 2024 CPO revealed a physician's order for hydralazine 25 mg by mouth every 12 hours as needed for pruritus (itching), ordered on 11/7/24 and discontinued on 11/16/24 at 10:55 p.m -This order was discontinued on 11/16/24 at 10:55 p.m., after the resident reported the technician had tried to give the wrong medication. -The November 2024 medication administration record (MAR) revealed Resident #6 had received one dose of hydralazine 25 mg on 11/7/24, 11/13/24, and 11/15/24. The pharmacist monthly review progress note on 11/10/24 at 1:12 p.m. revealed the medication regimen review (MRR) was completed. -This review was documented during the time of the active hydralazine order and administration. A nursing progress note on 11/16/24 at 11:00 p.m. documented Resident #6 requested hydroxyzine for itching. Resident #6 was taking hydroxyzine for itching as needed. The medication was discontinued on 11/7/24 and hydralazine was ordered for itching. The resident was assessed and there were no abnormalities found. Resident #6 reported hydralazine caused hypotension (low blood pressure) in the past and declined taking the medication for itching. The registered nurse (RN) called the provider regarding the resident's request for hydroxyzine.The resident had not had the medication today, but reports feeling anxious about it being on medication list. An order was received to discontinue the hydralazine and a new physician's order was obtained for hydroxyzine 25 mg as needed every 12 hours for pruritus. The resident's blood pressure was monitored every four hours for 24 hours to ease the resident's anxiety. The November 2024 CPO revealed the following physician's orders: -Hydroxyzine 25 mg by mouth every 12 hours as needed for pruritus, ordered on 11/16/24; and, -Take Resident #6's blood pressure every four hours for the next 24 hours and to call the provider if systolic blood pressure reading was less than 100, ordered on 11/16/24. D. Staff interviews CNA-Med #1 was interviewed on 12/17/24 at 7:19 p.m. CNA-Med #1 said on 11/16/24, Resident #6 asked for an as needed medication. CNA-Med #1 said he looked at the physician's orders and saw the hydralazine as needed order. He said he did not know it was a blood pressure medication. CNA #1 said Resident #6 then told him, this is not the right med, and she refused to take it. CNA #1 said he then told the charge nurse and that was when they discovered it was the wrong medication. He said he did not administer the medication to Resident #5 on 11/16/24. The registered pharmacist consultant (RPH) was interviewed on 12/18/24 at 10:08 a.m. The RPH said hydralazine was a medication used for high blood pressure, not for itching. She said hydralazine could be a high risk medication if it decreased a resident's blood pressure too much. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RPH said if Resident #6 had received more doses of hydralazine, her blood pressure could have dropped. The RPH said if the medication caused a drop in blood pressure, it could cause the resident to have dizziness or fall. The RPH said based on the information she had, the hydralazine was ordered incorrectly on 11/7/24. She said the hydralazine and the hydroxyzine were very common look alike, sound alike medications. The RPH said the pharmacists did a double take to make sure the medication ordered was correct. The RPH said when the nurse signed the MAR for a particular medication, it indicated that the medication was given. The RPH said it appeared that the nurse practitioner (NP) accidentally put in the hydralazine order and discontinued the hydroxyzine order on 11/7/24. The RPH said there was not a physician's order for hydroxyzine 11/7/24 to 11/16/24. She said Resident #6's blood pressure remained stable when she was administered the three doses of hydralazine. The RPH said if Resident #6 had been on other medications for high blood pressure, the outcome could have been worse. The NP was interviewed on 12/18/24 11:30 a.m. The NP said she did not remember if she was in the building or if a licensed nurse took the hydralazine order via the telephone for Resident #6. She said she did not recall the situation. She said she did not think she would have ordered hydralazine but she may have. The NP said she just knew the medication was wrong. She said she was prescribed the hydroxyzine. The resident's primary care physician (PCP) #1 was interviewed on 12/18/24 at 12:05 p.m. PCP #1 said she was made aware of the medication error involving Resident #6 last week. She said safety measures were put into place so medication errors did not occur. She said however, unfortunately they all failed. She said the licensed nurse was to verify the order was correct prior to ordering the medication, the pharmacist was to verify the medication with the diagnosis prior to sending out the medication to the facility and the provider was to verify the medication order was correct prior to signing the order. PCP #1 said when she learned of this medication error, she asked all providers to not sign off on batch verbal orders (many orders at one time). She said she instructed the providers to review each order separately prior to signing them. PCP #1 was interviewed a second time on 12/18/24 at 1:28 p.m. PCP #1 said Resident #6 was not harmed by receiving the wrong medication. She said the biggest risk to the resident was hypotension (low blood pressure). The PCP said the possibility existed that Resident #6 could have been harmed from receiving doses of the wrong medication, but it was unlikely. She said Resident #6 had blood pressures that were high enough to support doses of hydralazine. PCP #1 said there were no plans to order antihypertensives (high blood pressure medications) for Resident #6. The DOCS was interviewed on 12/18/24 at 2:33 p.m. The DOCS said the progress note documented in Resident #6's electronic medical record (EMR) summarized the incident. He said a medication error report should have been started at the time, but was not. He said he now had started one. The DOCS said the order was entered by a nurse educator who reviewed the residents' orders on 11/7/24 and then the order was signed off by the NP. He said it was standard nursing practice to sign off orders and there was no specific training provided at the facility for this purpose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DOCS said he agreed with PCP #1 that the nurse was supposed to verify the order prior to entering the order in the EMR, the pharmacist was supposed to check the drug prior to sending to the facility and the provider should have verified the drug was correct. The DOCS said he did not know why the correct drug for itching (hydroxyzine) was discontinued on 11/7/24. The DOCS said the facility had assigned education to nurses and a consultant was going to provide in person education to staff. The DOCS said a daily order review was implemented due to this event. He said the facility was working with the pharmacy to develop an action plan moving forward. The DOCS said a medication incident report should have been created when the medication error was discovered and he had now created an incident report (during the survey). The RPH was interviewed a second time on 12/18/24 at 3:21 p.m. The RPH said the pharmacists did not check the indication for medications when they dispensed the medications to the facility. She said the pharmacists check for allergies and drug interactions. The RPH said the pharmacist would not have stopped the hydralazine from being dispensed due to the wrong diagnosis. The RPH said the consultant pharmacist's role was to check for the diagnoses when they performed the monthly medication regimen review for residents. The RPH was interviewed a third time on 12/19/24 at 11:20 a.m. The RPH said the documentation in the EMR for MRR completed on 11/10/24 meant the MRR was downloaded and review of medications had begun. The RPH said the hydralazine order for Resident #6 was brought up at the Psych Pharm review meeting on 11/13/24 and a facility representative said the medication would be discontinued. The RPH said she did not know why the medication was not discontinued on 11/13/24 (the medication was later discontinued on 11/16/24 after Resident #6 identified the incorrect medication). II. Failed to prevent excessive acetaminophen dosage A. Professional reference According to manufacturer of Tylenol Professional, revised 2023, retrieved on 12/26/24 from: https://www.tylenolprofessional.com/products-dosage-adult, Acetaminophen is not to exceed six 500 mg caplets in 24 hours (3000 mg/day), unless directed by a doctor. A professional discretionary dosage: If pain or fever persists at the total labeled daily dose, healthcare professionals may exercise their discretion and recommend up to 4000 mg per day. B. Resident #44 1. Resident status Resident #44, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included chronic osteomyelitis (bone infection), post-procedural pain, dementia and chronic obstructive pulmonary (lung) disease. The 10/7/24 minimum data set (MDS) assessment revealed Resident #44 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required supervision or set-up assistance for eating and personal hygiene and required supervision with lower body dressing. 2. Observation (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 12:18 p.m., licensed practical nurse (LPN) # 1 was administering acetaminophen 650 milligrams (mg) and hydrocodone 7.5 mg/acetaminophen 325 mg to Resident #44. -This represented a total dose of 975 mg acetaminophen given at that time. 3. Record review A review of the October 2024 CPO revealed the following physician's orders: -Acetaminophen 1000 mg by mouth three times a day for pain (active order from 10/4/24 to 11/11/24). -Hydrocodone 7.5 mg/ acetaminophen 325 mg four times a day for chronic pain (active order from 10/4/24 to 11/4/24). -Acetaminophen 1000 mg by mouth every 24 hours as needed for pain, not to exceed 3000 mg per day (active order since 9/30/24). The October 2024 medication administration record (MAR) revealed Resident #44 received 4300 mg acetaminophen on the following dates: 10/18/24, 10/20/24, 10/23/24, 10/27/24, 10/28/24 and 10/30/24. -If all scheduled doses were administered as ordered, the resident would have received 4300 mg per day. The resident declined acetaminophen on several occasions. If all scheduled doses and the as needed acetaminophen doses were administered as ordered, the resident would have received 5300 mg per day. A review of the December 2024 CPO revealed Resident #44 had the potential to receive up to 4250 mg per day of acetaminophen. Active orders included: -Acetaminophen 650 mg by mouth four times a day for pain; -Hydrocodone 7.5 mg/ acetaminophen 325 mg four times a day for chronic pain; and, -Acetaminophen 1000 mg by mouth every 24 hours as needed, not to exceed 3000 mg, acetaminophen per day (scheduled doses together equaled 3250 mg, not including as needed dose). B. Staff interviews RN #1 was interviewed on 12/16/24 at 3:00 p.m. RN #1 said after she reviewed Resident #44's orders, she realized the resident had received 3250 mg of acetaminophen daily per scheduled doses and had the potential to receive an additional 1000 mg of acetaminophen if the as needed order were given. LPN #1 was interviewed on 12/16/24 at 3:05 p.m. LPN #1 said the pharmacist and the nurses were responsible for checking orders to ensure that residents did not receive too much acetaminophen. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RPH was interviewed on 12/16/24 at 3:45 p.m. The RPH said the limitation of acetaminophen containing products was a newer practice over the past eight years and was dependent on the resident's status. The RPH said Resident #44 should not receive more than 4000 mg acetaminophen per day. The RPH said the as needed order for acetaminophen should have been discontinued prior to the scheduled acetaminophen dosing. The RPH said the pharmacist should probably have caught that the 3000 mg limitation was not standard of practice. The RPH was interviewed a second time on 12/16/24 at 4:11 p.m. The RPH said she spoke with the PCP #1 who said Resident #44 could receive up to 4000 mg per day of acetaminophen and the PCP contacted the facility to eliminate the as needed acetaminophen order. The RPH said the resident could have received up to 4250 mg acetaminophen per day as it had been ordered if staff had not paid attention to it. The RPH was interviewed a third time on 12/17/24 at 11:13 a.m. The RPH said according to the MAR, Resident #44 received 4300 mg acetaminophen on 10/18/24, 10/20/24, 10/23/24, 10/27/24, 10/28/24 and 10/30/24. The RPH said liver toxicity could occur due to doses above 4000 mg. She said symptoms of this toxicity could include nausea, vomiting and agitation. The RPH said the resident did not develop toxicity, but the back to back 10/27/24 and 10/28/24 administration of 4300 mg acetaminophen were concerning because they were back to back and there was a higher potential for the resident to experience toxicity during that time. The director of nursing (DON) and the DOCS were interviewed together on 12/17/24 at 3:05 p.m. The DON said the acetaminophen maximum daily dose was limited to 3000 mg, then was increased to 4000 mg if the resident did not have other conditions which compromised the resident. The DON said she would expect a nurse to abide by an order which limited acetaminophen to 3000 mg per day. The DOCS said the pharmacy completed an audit for residents with acetaminophen orders on 12/16/24 (during the survey) to ensure appropriate dosing. The DOCS said PCP #1 had requested removal of as needed acetaminophen 1000 mg orders. The DON said the 4300 mg of acetaminophen administered to Resident #44 on six dates could have affected her liver. PCP #1 was interviewed on 12/18/24 at 12:22 p.m. PCP #1 said she had reviewed documentation for several residents at the facility who were scheduled for excessive amounts of acetaminophen. PCP #1 said a performance improvement project had been initiated to review medication lists for every resident and verify acetaminophen doses from all sources (during the survey). PCP #1 said Resident #44 should not receive more than 3500 mg acetaminophen per day based upon her risk factors. PCP #1 said the 1000 mg as needed acetaminophen order had been removed from Resident #44's orders. She said the nursing staff were responsible for ensuring residents did not receive too much acetaminophen. III. Facility follow-up The Medication Error Action Plan, dated 12/17/24 (during the survey), was provided by the DOCS on 12/18/24 at 3:13 p.m. The action plan included the following: -Residents involved in medication errors were assessed and monitored for complications without significant findings (completed 12/18/24). -Risk management incident reports were created for both incidents to include notification to providers (completed 12/18/24). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All licensed nurses have been assigned training on medication administration (completed 12/18/24). -All licensed nurses will complete a medication administration competency (planned completion 12/24/24). -Audit completed by pharmacy consultant to ensure no further issues noted with acetaminophen dosing (completed 12/18/24). -Audit completed for antianxiety and antihypertensive medications to ensure appropriate diagnoses with no issues identified (completed 12/18/24). -Medical director notified of medication errors. Medical director has initiated performance improvement plan for providers (completed 12/18/24). -Agency nursing staff to be oriented prior to working first shift in community QM to provide updated agency orientation packet (ongoing). -Orders to be reviewed daily by designee to ensure appropriate diagnosis and medication. (ongoing). -Quality mentor to complete random weekly med pass observations (ongoing). -Review action plan at next QAPI meeting (ongoing).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Thornton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Thornton Pkwy Thornton, CO 80229	

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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 0800

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on observations, record review and interviews, the facility failed to provide each resident with a nourishing, palatable and well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences for two (#48 and #61) of six residents out of 41 sample residents.

Specifically, the facility failed to:

-Provide a balanced menu with a variety; and,

-Provide alternate items of preference for Resident #61 and #48 when requested.

I. Provide a balanced menu with a variety of starch options

A. Facility policy and procedure

The Resident Food Preferences policy, revised July 2017 was provided by the director of clinical services (DOCS) on 12/18/24 at 9:42 a.m. The policy read in pertinent part, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. Upon the resident's admission or within 24 hours after his/her admission, the dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. The dietitian and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. The resident has a right not to comply with therapeutic diets. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with.

The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. The facility's quality assessment and performance improvement (QAPI) committee will periodically review the issues related to food preferences and try to identify more widespread concerns about meal offerings, food preparation.

B. Resident interviews

Resident #61's representative was interviewed on 12/11/24 at 2:45 p.m. The resident's representative said the food was repetitive and it looked like the same thing over and over, and the menu lacked variety.

Resident #24 was interviewed on 12/11/24 at 4:44 p.m. Resident #24 said the food was repetitive and that he did not like the taste of the food. He said the facility served too much chicken. He said the food was not good.

(continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #47 was interviewed on 12/11/24 at 5:30 p.m. Resident #47 said the food quality was poor and attending the food meetings did not make a difference. Resident #47 said he talked to the new dietary manager (DM), who had been at the facility for almost three months, about various things and he was told to give it time. C. Resident group interview The resident group interview was conducted on 12/17/24 at 1:05 p.m. The group consisted of five residents (#115, #28, #4, #16 and #17) who were interviewable based on assessment by the facility. The residents said they continued to have concerns about the food. The residents' concerns were as follows: -The menu was repetitive and carrots, rice and potatoes were served too much; and, -Mixed vegetables were served too frequently. The residents said they had a food committee and they had complained about the food during resident council meetings. However, the group said they felt they were not listened to by the facility. The residents said the kitchen staff needed to take pride in their cooking. D. Record review The 10/21/24 resident council meeting minutes were provided by the DOCS on 12/17/24 at 10:00 a.m. The minutes documented the residents voiced that too much rice was being served at meals and residents wanted more of a variety in menu choices. A four week cycle menu was provided by the nursing home administrator (NHA) on 12/12/24 at 11:12 a.m. A review of the week two menu (served during the survey) revealed repeated menu items. Potatoes were a repeated side item for three of the four lunch and dinner meals on the following days: -On 12/15/24 the dinner menu was shepherds pie as the main entree and contained potatoes. -On 12/16/24 the lunch menu was Salisbury steak served with a side of mashed potatoes. -On 12/16/24 the dinner menu was breaded fish on a bun and served with potato wedges. Pasta was a repeated side item for four of the six lunch and dinner meals on the following days: -On 12/19/24 the lunch menu was Italian sausage with parmesan noodles. -On 12/20/24 the lunch menu was cornflake chicken breast with macaroni and cheese. -On 12/20/24 the dinner menu was meatballs with marinara sauce and spaghetti noodles. -On 12/21/24 the lunch menu was chicken alfredo with spaghetti noodles. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Staff interviews The dietary manager (DM) was interviewed on 12/17/24 at approximately 1:30 p.m. The DM said the facility staff had not mentioned to her that the residents had complained the menus were repetitive. The DM said normally if a resident complained a CNA would inform the dining staff, and bring the resident's initial meal tray to the kitchen to get the resident something else to eat. District supervisor (DS) #2 was interviewed on 12/17/24 at approximately 1:30 p.m. DS #2 said she had previously helped the facility with menu management and had consulted with the regional dietitian to review the menus including the residents' likes and dislikes. DS #2 said if the residents prefer, for example, to have fish removed from the menu, the residents could list another preferred menu item, give the managers that feedback and then make the changes to the menu. DS #2 said she would start reviewing the menus to change out some of the repetitive options. II. Failed to provide items of preference for Resident #61 and Resident #48 A. Resident #61 1. Resident status Resident #61, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included sepsis (infection of the blood), acute respiratory failure, pulmonary fibrosis (scarring of lung tissue) and late onset dementia. The 11/24/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. Resident #61 was dependent on assistance for bathing, needed substantial assistance with transfers, dressing, toileting hygiene and oral hygiene, supervision with personal hygiene and set up help with eating. 2. Resident representative interview and observations Resident #61's representative was interviewed on 12/11/24 at 2:45 p.m. The representative said she was worried about Resident #61's weight because he did not eat well. The representative said she complained about the food to multiple staff at the facility and told a staff member Resident #61 was not eating well and needed encouragement to eat. The representative said she requested a menu and the certified nurse aides (CNA) told her they were unsure where to find a menu. The representative said Resident #61 finished the Mexican food the family brought him from home and the resident preferred Mexican food. The following was observed during the 12/11/24 noon meal: At 12:01 p.m., the room trays were delivered to the east unit.CNA #8 delivered a tray to Resident #61. She assisted the resident into his chair by the bedside table by holding his hand for assistance. CNA #8 set the tray in front of the resident and left the room. The following was observed during the 12/16/24 noon meal: (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:05 p.m. CNA #9 brought Resident #61 his tray. She assisted him to sit in a chair. CNA #9 set a meal tray in front of Resident #61 and left the room. -However, staff did not offer Resident #61 any items of preference or encouragement. 3. Record review Resident #61's nutrition care plan, initiated 11/27/24, documented he had a nutritional problem or potential nutritional problem related to sepsis, Alzheimer's disease, polyneuropathy (nerve disease causing numbness and pain), polyosteoarthritis (arthritis in multiple joints), GERD and fatty liver. The family reported a history of weight loss prior to his admission to the facility. Pertinent interventions initiated 11/27/24 included obtaining the resident's food preferences and offering as able and offering food alternates of equal nutritional value. A review of the resident's electronic medical record (EMR) revealed the following: An 11/27/24 progress note written at 4:25 p.m. documented Resident #61's family member asked if there was an alternate menu and if the resident could have a banana and yogurt for breakfast, and Mexican food only for lunch and dinner to eat. An 11/27/24 progress note documented written at 5:47 p.m. documented Resident #61's daughter brought food for the resident to eat at dinner and said she would try to contact the dietary department to figure out food options for Resident #61. A 12/1/24 progress note written at 5:36 p.m. documented the facility told Resident #61's representative the facility could offer choices available in the kitchen but could not force feed the resident. If the resident had favorite food items he would eat, the facility could provide them and make sure the resident had them to eat. Resident #61's food and nutrition food preferences, dated 12/9/24 were provided by the DOCS on 12/17/24 at 9:39 a.m. The food preferences revealed the resident preferred Mexican foods, bananas, yogurt, beans, rice, cheese, chicken, sweets and fruit. The resident's least favorite foods were listed as pasta, carbohydrates and red meat. He had recently lost weight. -However, Resident #61's care plan was not updated to reflect Resident #61's preferences. 4. Staff interviews CNA #9 was interviewed on 12/17/24 at 11:00 a.m. CNA #9 said Resident #61 needed encouragement to eat. CNA #9 said she heard Resident #61 had complained about the food quality previously and she would tell the dietitian if she received a complaint about food quality. The district supervisor (DS) #1 was interviewed on 12/17/24 at approximately 1:30 p.m. DS #1 said a resident's food preferences were usually captured within 24 hours of the resident's admission to the facility. DS #1 said the DM would then enter the preferences into the menu system so they appeared on the resident's meal card. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM was interviewed on 12/17/24 at approximately 1:30 p.m. The DM said she was not familiar with Resident #61's meal preferences or that he preferred Mexican food. 20287 B. Resident #48 1. Resident status Resident #48 age 68, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified macular degeneration (decreased vision), dysphagia, depression and cognitive communication deficit. The 9/27/24 MDS assessment showed the resident had cognitive impairments with a BIMS score of three out of 15. The resident was prescribed a therapeutic mechanically altered diet. 2. Record review The December 2024 CPO revealed a physician's order for a regular diet, dysphagia advanced texture and regular consistency. The order documented she could have a regular grilled cheese. 3. Observation On 12/16/24 at 5:24 p.m., the resident had not eaten her meal. She said she would like to have a grilled cheese with ham sandwich.CNA #10 was alerted that Resident #48 wanted a a ham and grilled cheese sandwich. CNA #10 went to the kitchen window to put in the request. The registered dietitian (RD) went to the kitchen window and said Resident #48 could not have the ham on the grilled cheese. At 5:36 p.m., the resident received a grilled cheese sandwich. The resident asked if there was ham on her sandwich. CNA #10 said no, and the resident asked why she did not get ham on her sandwich the CNA said it was because of her diet order. 4. Staff interviews CNA #10 was interviewed on 12/16/24 at 5:27 p.m. CNA #10 said she had requested a ham and cheese grilled cheese sandwich for Resident #48 however, the RD told him she could not have one and ordered only a grilled cheese sandwich. The RD was interviewed on 12/17/24 at 6:02 p.m. The RD said Resident #48 was prescribed a dysphagia diet and she could have a grilled cheese sandwich. She said she could not have the ham for safety reasons. She said she reached out to the speech therapist and she did update the diet so that she was able to have chopped ham. The RD was interviewed again on 12/18/24 at 4:00 p.m. The RD said when Resident #48 requested ham on her sandwich, she thought the resident was only approved to have a grilled cheese sandwich and not ham because of the residents prescribed modified texture diet. The RD said she was being over cautious when she said the resident could not have ham on her sandwich.

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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. 47151 Based on interviews, observations and record review, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value, were palatable in taste, appearance and temperature. Specifically, the facility failed to ensure the residents' food was palatable in taste, texture, appearance and temperature. Findings include: I. Resident interviews Resident #13 was interviewed on 12/11/24 at 10:38 a.m. Resident #13 said the food was not hot. Resident #35 was interviewed on 12/11/24 at 2:17 p.m. Resident #35 said the food was never hot. Resident #61's representative was interviewed on 12/11/24 at 2:45 p.m. The resident's representative said Resident #61 told her the food had no flavor. Resident #6 was interviewed on 12/11/24 at 3:25 p.m. Resident #6 said the food was not good. Resident #6 said the grilled cheese sandwiches were not cooked correctly and were not grilled, but microwaved instead. Resident #6 said the food was often served cold and had no flavor. Resident #24 was interviewed on 12/11/24 at 4:44 p.m. Resident #24 said the food was repetitive and that he did not like the taste of the food. He said the facility served too much chicken. He said the food was not good. Resident #47 was interviewed on 12/11/24 at 5:30 p.m. Resident #47 said the food quality was poor and attending the food meetings did not make a difference. He said a hamburger patty could be thrown at the wall and it would put a hole in the wall. Resident #47 said he talked to the new dietary manager (DM), who had been at the facility for almost three months, about various things and he was told to give it time. Resident #47 said the food was overcooked and crusty. II. Observations During a continuous observation on 12/12/24, beginning at 4:15 p.m. and ending at 5:05 p.m., the following was observed during the meal preparation and service in the main kitchen: At 4:25 p.m. cook (CK) #1 took the temperature of the hot food. The philly cheesesteak sandwiches were in a food service pan fully assembled for meal service. The temperature of the tater tots was 99 degrees F. The temperature of the mixed vegetables was 160 degrees F. At 4:30 p.m. assembly of resident meal trays for the west hall room tray delivery started and the meal trays were delivered to the west hall at 4:39 p.m. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:40 p.m. assembly of resident meal trays for the east hall room tray delivery started. At 4:44 CK #1 pulled a second pan of assembled philly cheesesteak sandwiches out of the hot holding pan and placed the sandwiches in the hot holding table for service. Resident meal trays were assembled and placed in the cart. At 4:45 p.m. the test tray was assembled and placed in the east hall room delivery cart. At 4:45 p.m. the cart with the test tray left the kitchen and arrived in the east hall at 4:46 p.m. At 4:47 p.m. the first room tray was delivered to a resident. At 4:56 p.m. the test tray was removed from the cart. The test tray was immediately evaluated by three surveyors after the last resident had been served their room try for dinner. The test tray consisted of a philly cheesesteak sandwich, tater tots, mixed vegetables and canned fruit for dessert. -The tater tots were 108 degrees F. -The mixed vegetables were 119.7 degrees F. -The tater tots were over-salted. The vegetables were overcooked and limp, with a bland flavor and dull color. The bun on the philly cheesesteak was hard and chewy on each end of the bread. A small portion of the cheese was burned. On 12/12/24 at 5:00 p.m., Resident #115 received her meal in the dining room. The resident attempted to eat the philly cheesesteak sandwich, but she did not. Resident #115 asked for a new sandwich because she said the bread was too hard. III. Resident group interview The resident group interview was conducted on 12/17/24 at 1:05 p.m. The group consisted of five residents (#115, #28, #4, #16 and #17) who were interviewable based on assessment by the facility. The residents said they continued to have concerns about the food. The residents' concerns were as follows: -The meals were often served cold; -The quesadillas and grilled cheese sandwiches were often served burnt; -The food had no flavor and was bland in taste; -The meat was tough, particularly the pork chops and chicken; -The tater tots served on the 12/12/24 evening meal were too salty; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The philly cheesesteak sandwich which was served 12/12/24 during the evening meal had hard bread and the residents did not the like cheddar cheese that was used rather than the traditional swiss cheese; -The vegetables were under cooked; -The menu was repetitive and carrots, rice and potatoes were served too much; and, -Mixed vegetables were served too frequently. The residents said they had a food committee and they had complained about the food during resident council meetings. However, the group said they felt they were not listened to by the facility. The residents said the kitchen staff needed to take pride in their cooking. IV. Record review Resident council meeting notes were reviewed for October 2024 and November 2024. The 10/31/24 resident council minutes documented the following comments from residents: -The chicken and pork were overcooked and tough; -Too much rice was served at meals; and, -The residents would like to have more variety. The 11/21/24 resident council minutes documented the following comments from residents: -The food was horrible. Residents left the dining room in disgust; -The pork and chicken were still too tough to eat; -Alternative meals were not offered; and, -Food was served cold. V. Staff interviews The nursing home administrator (NHA) was interviewed on 12/18/24 at 12:25 p.m. The NHA said he had heard concerns about food quality and it was discussed during resident council meetings. The NHA said he had sampled some random meals and the meals he sampled had been good. The NHA said he had not sampled a meal sent in the room tray cart. The NHA said the facility had recently switched food vendors and some residents perceived that the food quality might be different but he had not noticed a difference. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM was interviewed on 12/18/24 at 3:00 p.m. The DM said when the facility held the food committee meeting with the residents, residents said there were concerns about the temperature of the food. The DM said the dietary staff, including herself, had tasted the food. The DM said the main issue she heard from the residents was about oatmeal in the morning and a few things from the menu were not as hot as they could be. The DM said she tasted a test tray about a week ago and there were no concerns with the test tray. District supervisor (DS) #1 was interviewed on 12/18/24 at 3:00 p.m. DS #1 said the facility completed a test tray audit before the 15th of every month to assess food quality. The DM said she thought the facility needed to build the sandwiches on the line during meal service instead of assembling them ahead of time for better quality. The DM said she was trying to train the staff to batch cook the tater tots and the tater tots served for the evening meal on 12/12/24 were cooked in one batch ahead of time. 20287

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to meet all the requirements for the provision of hospice care for one (#9) of two residents out of 41 sample residents. Specifically, the facility failed to ensure the hospice agency notes regarding Resident #9's care were easily accessible to the facility staff in an attempt to effectively coordinate care with the hospice agency. Findings include: I. Resident #9 A. Resident status Resident #9, age greater than 65 was admitted [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included acute kidney failure, history of falling and dementia. The 9/20/24 minimum data set (MDS) assessment documented the resident had both short term and long term memory impairments and had severely impaired decision making skills per staff assessment. The resident was dependent on staff for activities of daily living (ADL). The MDS assessment indicated the resident was receiving hospice services. B. Resident representative interview Resident #9's representative was interviewed on 12/18/24 at 10:30 a.m. The representative said Resident #9 was receiving hospice services. She said she was not sure if the chaplain had been in to see her mother through hospice. She said a chaplain was supposed to visit. C. Record review The December 2024 CPO revealed a physician's order for Resident #9 indicating the resident was admitted to hospice on 12/18/23. The care plan, revised on 6/26/24, documented the resident received additional support services through hospice. Pertinent interventions included the hospice nurse visited one to times a week, the hospice certified nurse aide (CNA) visited twice a week to assist with showers, hospice staff was to participate in care, and the facility staff were to work cooperatively with the hospice team to ensure the residents spiritual, emotional, intellectual, physical and social needs were met. A hospice notebook was provided by registered nurse (RN) #1 on 12/17/24 at 10:00 a.m. Review of the notebook revealed the last note in the notebook from hospice was from 9/5/24 from the hospice RN. The CNA's last note was 10/31/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic medical record (EMR) failed to reveal any progress notes from the hospice services provider. D. Staff interviews RN #1 was interviewed on 12/17/24 at 10:00 a.m. RN #1 said Resident #9 was on hospice services. She said the hospice nurse came once or twice a week. She said when the hospice RN visited the resident she would check in with the facility nurse and would also inform the staff of any changes. She said the hospice CNA visited twice a week to provide a shower to Resident #9. RN #1 said a social worker and a chaplain also visited. She said the facility had a notebook which was used for hospice documentation. She said any other notes would be scanned into the EMR. RN #1 said she reviewed the medical record and she was not able to find any up to date notes from hospice. She said the health information department would scan the documents into the EMR. The health information specialist (HIS) was interviewed on 12/17/24 at approximately 10:30 a.m. The HIS said there were no notes for Resident #9 from the hospice agency. She said she would contact the agency and then would develop a plan to ensure the hospice notes were received timely.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47151 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance and performance improvement (QAPI) program committee failed to operate a quality assurance (QA) program in a manner to identify and address concerns related to quality of care. Findings include: I. Facility policy and procedure The Quality Management Plan/Quality Assurance and Performance Improvement (QMP/QAPI) Plan policy, dated 9/29/23, was provided by the director of clinical services (DOCS) on 12/19/24 at 2:43 p.m. It read in pertinent part, The facility has an on-going quality management and quality assurance and performance improvement (QAPI) program designed to objectively and systematically monitor and evaluate the residents' care and health care services. The comprehensive program is designed to provide care that is optimal within the available resources and is consistent with the achievable goals. The objectives include to ensure that monitoring quality of residents' care is performed systematically and continuously, ensure communication among all departments in improving resident care and identifying programs through the use of on-going monitors by focusing on identification, analysis and resolution of problems, and evaluate the results of actions taken by each department and maximize the use of resources available within the facility. It is the goal of the facility to integrate QMP/QAPI into all care and service areas of the organization. The following will be key areas of focus of the facility: clinical care, quality of life, resident choice and care transitions. Effective performance improvement efforts will focus on the development, maintenance and periodic improvement of systems that influence organizational outcomes. II. Cross-referenced citations Cross-reference F561 self-determination: The facility failed to honor resident choices. Cross-reference F566 right to perform facility services or refuse: The facility failed to ensure residents were compensated timely for work performed. Cross-reference F567 management of personal funds: The facility failed to ensure personal funds accounts were managed adequately. Cross-reference F584 safe, clean, comfortable and homelike environment: The facility failed to ensure residents were provided with a safe, clean, comfortable and homelike environment. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F610 investigation of an alleged violation: The facility failed to investigate allegations of abuse. Cross-reference F622 transfer and discharge requirements: The facility failed to ensure residents were allowed to remain in the facility. Cross-reference F626 permitting residents to return to the facility: The facility failed to ensure a resident was able to return to the facility. Cross-reference F661 discharge summary: The facility failed to ensure an appropriate discharge summary was in place. Cross-reference F677 activities of daily living for dependent residents: The facility failed to provide appropriate treatment and services to maintain or improve residents' ability to perform activities of daily living. Cross-reference F679 activities meet the interests and needs of each resident: The facility failed to ensure residents received an ongoing program of activities designed to meet needs and interests, and promote physical, medical and psychosocial well-being. Cross-reference F684 quality of care: The facility failed to provide treatment and care in accordance with professional standards of practice. Cross-reference F685 treatment or devices to maintain hearing and vision: The facility failed to ensure proper treatment and services to maintain hearing and vision. Cross-reference F689 free of accident hazards: The facility failed to ensure residents remained as free from accident hazards as possible. Cross-reference F698 dialysis communications: The facility failed to ensure residents received dialysis services consistent with professional standards of practice. Cross-reference F760 significant medication errors: The facility failed to ensure residents were free from significant medication errors. Cross-reference F761 storage and labeling of medications: The facility failed to ensure all drugs and biologicals used in the facility were properly stored and labeled. Cross-reference F800 diet meets the needs of each resident: The facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Cross-reference F804 nutritive value and food palatability: The facility failed to ensure residents were provided with food cooked and served in a manner that conserved nutritive value, flavor, appearance, texture and at an appetizing temperature. Cross-reference F812 kitchen sanitation: The facility failed to prepare and serve food in a sanitary manner. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F880 infection control: The facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection. III. Staff interviews The nursing home administrator (NHA), the regional director of operations (RDO) and the DOCS were interviewed together on 12/19/24 at 2:17 p.m. The NHA said the QAPI committee met monthly with the interdisciplinary team (IDT) and over video call if the medical director could not attend in person. The NHA said the QAPI format reviewed various topics on a worksheet that were marked as compliant or non-compliant. The RDO said if the facility identified a major issue that could not wait to be addressed until the next QAPI meeting, the facility called a meeting sooner rather than later. The DOCS said the facility identified smoking assessments were not completed and reviewed the process multiple times but had not identified the assessments as a systemic issue. The DOCS said enhanced barrier precautions (EBP) was identified as an issue under the previous director of nursing (DON) and said it was an oversight due to changing facility leadership positions. The NHA said the facility had not identified residents needing assistance at meal time as an issue. The NHA said the facility had a schedule for managers to be present in the dining room at meal time and observe if residents needed additional assistance. The NHA said the facility had discussed activities but had not identified it as a concern and activities had their own section to complete on the QAPI form. The RDO said the facility team did discuss residents scheduled for one-to-one activities. The DOCS said the new activity director (AD) had been with the facility for about a month and was trying to create some stability and revamp the activity department. The RDO said the facility instituted floor huddles to discuss with the facility staff what issues the staff had identified, to build culture and create an open environment for staff to discuss concerns.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Care Center	501 Thornton Pkwy Thornton, CO 80229

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.

Specifically the facility failed to:

-Ensure staff wore appropriate personal protective equipment (PPE) while changing a resident's bedding who was on enhanced barrier precautions (EBP);

-Ensure the water management program (WMP) identified specific areas where legionella could grow and spread and decided where and how to monitor control measures to prevent legionella and waterborne pathogen growth and document the monitoring;

-Ensure staff followed appropriate hand hygiene during resident care and ensure shared vital signs equipment was sanitized between use; and,

-Ensure residents were offered hand hygiene at meals and staff performed appropriate hand hygiene during room tray delivery.

Findings include:

I. Failure to ensure staff wore the appropriate personal protective equipment

A. Professional reference

The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 12/23/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part,

Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities.

Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.

Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care: any skin opening requiring a dressing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Facility policy and procedure The Enhanced Barrier Precautions policy, dated 1/6/23, was provided by the director of clinical services (DOCS) on 12/17/24 at 6:58 p.m The policy read in pertinent part, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents. Residents with MDRO or who have indwelling medical devices will have an order written for initiation of EBP. A care plan will be initiated for the use of EBP. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and complicated wound care. EBPs are indicated if contact precautions do not otherwise apply, for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBP's remain in place for the duration of the resident's stay or discontinuation of the indwelling medical device that placed them at increased risk as they can still serve as a source of transmission. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. C. Resident interview and observation Resident #1 was interviewed on 12/12/24 at 9:25 a.m. Resident #1 said he went to dialysis appointments on three days a week. Resident #1 had a fistula on his right arm. D. Observations On 12/16/24 the following was observed: Resident #1 had an EBP sign on his door. The sign read in pertinent part, Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, transferring, providing hygiene, changing briefs or assisting with toileting. The cart is labeled with an EBP cart with an orange label. Certified nurse aide (CNA) #7 entered room Resident #1's room at 10:03 a.m. and carried two clear trash bags into the room. CNA #7 while wearing gloves, removed an incontinence pad from Resident #1's bed and placed it in the trash. CNA #7 then pulled up the blankets on Resident #1's bed toward the head of the bed and pulled the blankets back again. CNA #7 placed two new incontinence pads on the bed and then pulled the blankets up over the bed and incontinence pads. On Tuesday 12/17/24 the following was observed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:56 a.m. Resident #1 was seated in his wheelchair in his room. CNA #7 and an unidentified staff member assisted Resident #1 in putting on his coat while Resident #1 was seated in his wheelchair. Neither staff member wore a gown. CNA #7 assisted Resident #1 inside his room and closed the door to Resident #1's room. At 9:57 a staff member opened the door and the Resident #1 had his coat fully on and the (mechanical lift) sling was on the back of his chair. The resident said he was going to dialysis. The unidentified staff member assisted the resident down the hallway in his wheelchair. CNA #7 continued to work in Resident #1's room and removed the bed sheets from Resident #1's bed and placed them against the wall in the room. CNA #7 was not wearing a gown. He removed his gloves and exited the room. -CNA #7 and the unidentified staff member failed to wear a gown while they assisted Resident #1 to put on his coat and while CNA #7 changed Resident #1's bedding. D. Staff interviews Registered nurse (RN) #2 was interviewed on 12/16/24 at 2:25 p.m. RN #2 said she did not remember if CNA #7 had on a gown when he assisted Resident #1 the morning of 12/16/24. RN #2 said CNA #7 had assisted the resident to get dressed for dialysis and she entered the room to be a second person for Resident #1's transfer. RN #2 said she did not don (put on) a gown because she did not provide direct care to Resident #1 and was only the second person in the room for his transfer. RN #2 said a Resident #1 was on EBP because he received dialysis treatment. She said CNA #7 had dressed Resident #1 and put him in the sling. CNA #6 was interviewed on 12/17/24 at 10:15 a.m. CNA #6 said staff should wear a gown when changing a resident's sheets if the resident was on EBP. CNA #6 said if a resident was on EBP there was a sign on the door with EBP instructions, especially if the resident had a catheter. CNA #6 said once care was completed, the staff removed the PPE and left the used PPE in the trash in the resident's room. She said everything inside the trash was removed when she exited the room. CNA #6 said staff should not don a gown if they did not provide direct care to a resident on EBP, only if staff provided patient care and handled sheets. CNA #7 was interviewed on 12/17/24 at 11:52 a.m. CNA #7 said he should have a gown on when he changed a resident's sheets and a resident was on EBP. CNA #7 said EBP were to decrease the chance of infection spreading. CNA #7 said he thought because Resident #1 left the room he no longer needed to wear a gown when he changed the resident's bedding. The DOCS was interviewed on 12/18/24 at 1:00 p.m. The DOCS said the facility had some new CNAs working. The DOCS said EBP training was done electronically. He said the EBP training was part of the onboarding process and should be reviewed on an ongoing basis. The DOCS said he identified EBP needed attention on an audit prior to the survey and assigned it to the previous DON to follow up on. The DOCS said EBP were discussed daily in the facility's morning meeting. 47960 II. Water management program A. Professional reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDC recommendations for Legionella (3/15/24) were retrieved on 12/20/24 from https://www.cdc.gov/control-legionella/php/wmp/index.html. It read in pertinent part, Many buildings need a water management program (WMP) for their building water system or specific devices. WMPs identify hazardous conditions and outline steps to minimize the health impact of waterborne pathogens. Developing and maintaining a WMP is a multi-step process that requires continuous review. The seven steps of a Legionella WMP are to: Establish a WMP team; describe the building water systems; identify areas where legionella could grow and spread; decide where to apply and how to monitor control measures; establish interventions when control limits are not met; ensure the program runs as designed and is effective and document and communicate all the activities. Use flow diagrams and a written description to describe the building water systems. Include details like: How water enters the building, how water is distributed in the building, location of hot tubs, water heaters or boilers, and cooling towers, and where the building connects to the municipal water supply. Identify where potentially hazardous conditions could occur in the building water systems. Examples include areas where water temperature could promote Legionella growth or where water flow might be low. Establish control measures and limits for each hazardous condition. Control measures are actions taken in the building water systems to limit growth and spread of Legionella. They can include adding disinfectant, cleaning, and heating. Control limits are acceptable values for the control measures being monitored. They can include a maximum, minimum, and range of values. Control points are locations where control measures are applied. B. Facility policy and procedure The Legionella Surveillance policy, not dated, was provided by the nursing home administrator (NHA) on 12/16/24 at 1:30 p.m. The policy read in pertinent part, Legionella surveillance is one component of the facility's water management plans for reducing the risk of legionella and other opportunistic pathogens in the facility's water systems. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies. Primary prevention strategies include: Cooling towers and potable water systems shall be routinely maintained. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. Non-potable water systems shall be routinely cleaned and disinfected. Nebulation devices shall be filled only with sterile fluid. Cold water shall be stored above 140 degrees Fahrenheit (F) and circulated at a minimum return of 124 (F). Stagnate - dead legs - Areas not in use by residents and staff are identified by maintenance and placed on a weekly flush and disinfection schedule. -The Legionella Surveillance policy did not identify specific areas and locations where legionella could grow and spread; and decide where to apply and how to monitor and document control measures. The policy failed to include specific facility locations monitored such as water filters, pipes, valves and fittings, and medical devices (such as CPAP machines). The policy did not include how to monitor and document the control measures. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/16/24 at 9:30 a.m. the southeast wing, resident rooms #55, #56, #57, #59, and #60, were observed to be empty of residents. The rooms were not occupied. D. Record review The water flush log was reviewed on 12/19/24. It revealed the unoccupied rooms were flushed in July 2024 and October 2024. E. Staff interviews The regional director of operations (RDO) was interviewed on 12/16/24 at 2:08 p.m. The RDO said the facility's legionella surveillance policies were reviewed annually and as needed in monthly quality assurance and performance improvement meeting (QAPI). -However, the policy did not contain a date it was reviewed. The maintenance director (MTD) was interviewed on 12/19/24 at 9:55 a.m. The MTD said the facility had a hallway of unoccupied resident rooms and these rooms contained dead legs (plumbing system with infrequent water flow). The MTD said these rooms had been unoccupied for several months. The MTD said he ran the water from one of the sinks in the southeast wing to check the water temperature and he maintained a log of his findings. He was not aware of any requirements to track the rooms or amount of time to run the water for legionella surveillance. The MTD said he went weekly to one of the unoccupied resident rooms to temperature check the water but he did not flush the toilets or run the faucets for any length of time outside of getting an accurate water temperature. -However, documentation of monitoring and disinfection were not available. 20287 III. Ensure staff followed appropriate hand hygiene during resident care and ensure shared vital signs equipment was sanitized between use A. Professional reference According to the CDC Recommendations for Hand Hygiene for Healthcare Workers, (2024), retrieved on 12/24/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, CDC provides the following recommendations for hand hygiene in healthcare settings. Know when to clean your hands: immediately before touching a patient and after touching a patient or a patient's surroundings. According to the CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, (2024), retrieved on 12/11/24 from https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html#:~:text=Ensure%20that%2C%20at%20a%20minimum,once%20daily%20or%20once%20weekly, Clean medical devices as soon as practical after use. Perform either manual cleaning or mechanical cleaning. Perform low-level disinfection for noncritical patient-care surfaces and equipment (blood pressure cuffs) that touch intact skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Observations Certified nursing aide (CNA) #7 was observed on 12/11/24 at 10:30 a.m. taking the blood pressure of a resident. CNA #7 then continued to the next task to answer a call light while still holding the blood pressure cuff and the thermometer. He did not perform handwashing after he left the room. CNA #7 then went into another resident's room to take the vital signs of another resident. The CNA did not clean the blood pressure machine prior to taking the vitals of the other resident. D. Staff interviews The IP was interviewed on 12/16/24 at 2:00 p.m. The IP said the staff should perform hand hygiene after each task and especially in between residents. She said she would provide education regarding hand hygiene. IV. Ensure staff followed appropriate hand hygiene during delivery of the meal trays. A. Professional reference The CDC (2024), Clinical Safety: Hand Hygiene for Healthcare Workers, was retrieved on 12/24/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part, Perform hand hygiene before touching a patient, after touching a patient or their surroundings, immediately after glove removal. According to Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022.) Basic Nursing: Thinking, Doing and Caring, (Third edition), pages 1601, 1604-1605, Use standard precautions to prevent the transmission of infection. Implement measures to prevent healthcare-associated infections (HAIs). HAIs are the leading complication of healthcare and one of the ten leading causes of death in the United States. Hand hygiene can remove transient flora (microbes acquired by touching objects or people). B. Observations During a continuous observation of the lunch on 12/11/24, beginning at 12:01 p.m. and ending at 12:28 p.m. the following was observed: At 12:01 p.m., the room trays were delivered to the East unit. Certified nurse aide (CNA) #8 delivered a tray to room [ROOM NUMBER]. She assisted the resident into the chair at the table by holding his hand for assistance. She did not offer hand hygiene to the resident. She did not perform hand hygiene when she left the room. At 12:07 p.m., CNA #8 proceeded to pass a room tray to room [ROOM NUMBER]. She put gloves on and assisted the resident in bed with positioning. She did not offer hand hygiene to the resident. There was no handwipe on the tray. At 12:10 p.m., CNA #7 was pouring drinks and placing them on the room trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:21 p.m., CNA #7 went into room [ROOM NUMBER]B and delivered the resident's meal. The CNA did not offer hand hygiene to the resident and did not perform hand hygiene for himself when he left the room. At 12:23 p.m., CNA #7 entered room [ROOM NUMBER]A, and delivered the resident's meal. The CNA did not offer hand hygiene to the resident, did not perform hand hygiene for himself when he left the room. At 12:26 p.m., CNA #7 entered room [ROOM NUMBER]B and delivered the resident's meal. The CNA did not offer hand hygiene to the resident and did not perform hand hygiene for himself when he left the room. At 122:7 p.m., CNA #7 went into room [ROOM NUMBER]A and delivered the resident's meal. CNA #7 did not offer hand hygiene to the resident and did not perform hand hygiene for himself when he left the room. At 12:28 p.m., CNA #7 went into room [ROOM NUMBER]A and delivered the resident's meal. He did not offer hand hygiene to the resident and did not perform hand hygiene for himself when he left the room. On 12/16/24 at t 12:03 p.m., CNA #9 served room [ROOM NUMBER] his meal. She did not offer hand hygiene to the resident. She did not perform hand hygiene when she left his room. At 12:05 p.m. the CNA #9 then proceeded to serve room [ROOM NUMBER] his tray. She assisted him to sit in the chair. She did not offer him hand hygiene prior to leaving the room. C. Staff interviews CNA #7 was interviewed on 12/11/24 at 12:31 p.m. CNA #7 said he did not touch anything in the room when he dropped off meal trays. He said he should have performed hand hygiene before and after each meal delivery. The IP was interviewed on 12/16/24 at 2:00 p.m. The IP said residents should be offered hand hygiene prior to receiving their meals. She said the staff had been educated about offering hand hygiene prior to meals. The IP said the staff should also perform hand hygiene after each task and especially in between residents. She said she would provide education again.