STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065195	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Ridge Health and Rehabilitation Center	1043 Ridge St Montrose, CO 81401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for two (#18 and #46) of 28 sample residents reviewed for respect and dignity. Specifically, the facility failed to: -Ensure Resident #18 did not remove his clothing in the common areas of the facility; -Identify communication techniques for Resident #46 to decrease the resident's frustration and allow her to effectively and consistently express her needs and wants; and, -Ensure the staff stopped and listened to Resident #46 when the resident yelled no, hurt and enough as she was pushed with her wheelchair and her foot was dragged under her wheelchair. Findings include: I. Facility policy and procedure The Dignity policy, revised February 2021, was provided by the nursing home administrator (NHA) on 12/10/24 at 1:30 p.m. It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Individual needs and preferences of the resident are identified through the assessment process. Staff promote, maintain and protect resident privacy, including bodily privacy. The Resident Rights policy, revised February 2021, was provided by the NHA on 12/10/24 at 1:30 p.m. It read in pertinent part, (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence, be treated with respect, kindness and dignity, communication with and access to people and services, both inside and outside the facility; and, privacy and confidentiality. II. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included dementia, Alzheimer's disease with late onset and need for assistance with personal care. The 11/14/24 minimum data set revealed Resident #18 had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. Resident #18 had no behavioral symptoms documented. B. Observations On 12/5/24 at 10:11 a.m. Resident #18 was in the common area without his shirt on and trying to reach out to another resident. During a continuous observations on 12/5/24, beginning at 1:19 p.m. and ending at 1:21 p.m. the following was observed: At 1:19 p.m. Resident #18 was in the common area near the nurse's station sitting in his wheelchair and positioned with his back to the nurse's station. Resident #18 had his right arm in the sleeve of his shirt but the rest of his shirt was off and laid in his lap. There were eight other residents in the common area. At 1:21 p.m. Resident #18 removed his shirt completely and continued reading a newspaper. Two staff members passed the resident in the common area and did not offer the resident assistance with putting on his shirt. At 1:23 p.m. Resident #18 attempted to put his right arm in his sleeve but could not pull the sleeve up past his elbow. One staff passed the resident in the common area and did not offer the resident assistance with putting on his shirt. At 1:24 p.m. Resident #18 again removed his shirt completely. Four staff members walked through the common area passing Resident #18 without his shirt on. At 1:25 p.m. Resident #18 again attempted to put his right arm in his sleeve and pulled his arm out. At 1:27 p.m. Resident #18 placed his right arm in the sleeve to his shirt but was unable to pull the sleeve up past his elbow. Resident #18 sighed loudly, took his arm out of the sleeve and placed his shirt in his lap and looked frustrated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:28 p.m. an unidentified staff member walked through the common area and saw Resident #18 without his shirt on. The staff offered to assist the resident and she put his shirt back on. At 1:35 p.m. Resident #18 was observed in a clean shirt with a pair of overalls on. -Resident #18 was in the common area around other residents without a shirt for 11 minutes. During continuous observations on 12/10/24, beginning at 1:54 p.m. and ending at 1:57 p.m At 1:54 p.m. Resident #18 was in the hallway near the dining room and removed his shirt. 11 other residents were participating in an activity in the dining room. Resident #18 was yelling help over and over outside of the activity room. At 1:55 p.m. a staff walked past Resident #18 and said hi Resident #16 and continued walking past him and did not offer to help him put his shirt back on. At 1:56 p.m. Resident #18 self-propelled in his wheelchair closer to the dining room. The activity director counted how many residents were in the dining room and walked past Resident #18. At 1:57 p.m. certified nurse aide (CNA) #1 walked by the resident and noticed Resident #16 was not wearing his shirt. CNA #1 sat his lunch box and coat on the dining room table and assisted the resident with putting his shirt back on. -Resident #18 was in the common area around other residents without a shirt for three minutes. C. Record review Resident #18's care plan, revised 11/14/24, revealed the resident often took his shirt off in common areas. The intervention was documented as assisting the resident with putting on a clean shirt if he removed his shirt. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 12/10/24 at 12:05 p.m. LPN #1 said Resident #18 removed his shirt in the common areas numerous times every day. LPN #1 said she did not know why the resident removed his shirt. She said the staff tried to redirect the resident to put his shirt back on but he usually removed his shirt anyway. LPN #1 said the other residents laughed and called Resident #18 the facility's stripper. LPN #1 said when Resident #18 removed his shirt, the staff took him to his room and placed two shirts on him or a shirt and overalls to prevent him from taking off his shirt around other residents. LPN #1 said the overalls restricted the resident the best and he was unable to remove his shirt. (Cross-reference F604 failure to be free from restraints) (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 12/10/24 at 1:59 p.m. CNA #1 said Resident #18 always removed his shirt and the staff were unable to figure out why. CNA #1 said when he saw Resident #18 without his shirt on he assisted the resident with putting it back on. He said other staff placed the resident in two shirts or a shirt and overalls. CNA #1 said it was not necessarily to restrain the resident but the idea was to make it harder for the resident to remove his shirt. The director of nursing (DON) was interviewed on 12/10/24 at 4:11 p.m. The DON said Resident #18 constantly removed his shirt. She said she asked the resident if he was hot, cold, itchy or uncomfortable and the resident was unable to answer. She said staff assisted the resident with putting his shirt back on or getting a clean shirt. She said staff were not supposed to place him in two shirts or a shirt and overalls to restrict or restrain the resident from undressing. The DON said Resident #18 liked wearing overalls because he was a farmer when he worked but the staff were not to use the clothing like a restraint. 40467 III. Resident #46 A. Resident status Resident #46, age greater than 65, admitted to the facility on [DATE]. According to the November 2024 CPO, diagnoses included atrial fibrillation (irregular heartbeat), vascular dementia, cognitive communication deficit, chronic pain, unsteadiness on feet, muscle weakness, abnormalities of the gate and mobility and dependence on the wheelchair. The 9/3/24 MDS assessment documented Resident #46 was cognitively intact with a BIMS score of 14 out of 15. She did not have rejection of care behaviors. According the MDS assessment, Resident #46 used a wheelchair for mobility. B. Observations On 12/4/24 at 12:43 p.m. Resident #46 was yelling extremely loud. The resident had garbled speech and repeatedly said no as she was being assisted in her wheelchair to the dining room. Her right foot was dragging underneath her wheelchair for approximately 15 to 20 feet before certified nurse aide (CNA) #2 stopped and told the resident she needed to pick up her feet. CNA #2 attempted to move the resident's wheelchair forward again. Resident #46's feet were not on the foot rests that were attached to the wheelchair. She had her left foot firmly planted on the floor in front of her to prevent the wheelchair from moving forward. The resident's right foot was extended back and under her wheelchair. The resident had garbled speech repeatedly and said no, enough and hurt could be identified. CNA #2 identified the foot under the wheelchair and slightly pulled the wheelchair back. The resident was able to pull her foot forward and lift feet up. The resident was taken to a dining room table. At 12:57 p.m. Resident #46 remained visibly upset. The resident continued to say no repeatedly in a loud and tearful tone as a staff member sat next to her asked her to calm down and if she was hurting. The resident said no proceeded to tap her hand on the table. During a continuous observation on 12/4/24, beginning at 2:35 p.m. and ending at 2:43 p.m., the following was observed: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:35 p.m. Resident #46 was heard from the hallway in her room. The resident loudly and repeatedly said no. At 2:39 p.m. CNA #4 exited a resident's room next store to Resident #46 with a bag of soiled items. She placed the soiled items in a hall closet/utility room. At 2:41 p.m. CNA #4 exited the room, walked past Resident #46's room, and left the hall as Resident #46 continued to loudly say no. At 2:42 p.m. CNA #4 returned to the hall and re-entered the neighbor's room. At 2:43 p.m. Resident #46's roommate turned on the call light. CNA #4 entered Resident #46's room. On 12/10/24 at 10:24 a.m the speech therapist (ST) entered Resident 46's room. The ST attempted to find Resident #50's communication sheet in the resident's room. The ST was unable to find the communication sheet. At 12:35 p.m. Resident #46 was in the lobby repeatedly saying no, no, no. LPN #2 approached the resident and offered her water. The resident accepted the water and then repeated the words no. At 12:55 p.m. a staff member approached the resident and asked her what she needed. The resident continued to say no. The staff member left the resident. At 12:56 p.m. the nursing home administrator (NHA) approached the resident and asked her if she wanted to go back to her room and lay down. Resident #46 said yes. The NHA informed the resident that she could lay down and the staff was waiting on two CNA's to be available. C. Resident representative interview Resident #46's representative was interviewed on 12/9/24 at 3:20 p.m. He said Resident #46 would say no but she did not always mean no when she said it. He said the ST used a communication board with pictures and words on it to work with her. He said he had not seen the communication board for a while. D. Record review The cognition care plan, dated 6/4/24, identified the care plan had interventions to help her understand related to cognitive deficits but not how to help her with communicating her needs and wants to staff. The cognitive care plan for communication read in part, use the residents preferred name, reducing any distractions, turing off the television radio and closing the door The care plan documented the resident understood consistent, simple, directive sentences and for staff to provide the resident with necessary cues, stop and return if agitated. -The care plan did not direct staff to use a communication sheet. C. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 was interviewed on 12/9/24 at 4:26 p.m. LPN #2 said Resident #46 had repetitive verbalization which made communication difficult but she would nod yes and no to indicate what she wanted. CNA #4 was interviewed on 12/9/24 at 6:42 p.m. CNA #4 said Resident #46 would usually repeat the word no so she would try to anticipate the resident's needs. She said the resident would say other words other than no at times. CNA #5 was interviewed on 12/9/24 at 6:51 p.m. CNA #5 said the resident would often say no when she was asked a question. CNA #5 said she would start to walk away and the resident would loudly and urgently say no repeatedly which would let her know Resident #50 meant to say yes. The DON was interviewed on 12/9/24 at 5:19 p.m. The DON said Resident #46 hollered if she needed or wanted something. She said the resident tried to say what she wanted but had difficulty speaking. She said the staff had to guess what she wanted. The DON said if the staff guessed wrong and did not understand the resident, she would become frustrated and raise the tone in her voice. The ST was interviewed on 12/10/24 at 10:02 a.m. The ST said Resident #46 was on her case load from 5/29/24 to 7/10/24. The ST said when the resident was first admitted to the facility (5/29/24) the resident was able to communicate in full sentences. The ST said the resident was at her highest level of ability for speech so speech therapy was discontinued. The ST said Resident #46 was restarted on speech therapy services after the resident had a decline in communication and had signs of dysphagia (difficulty swallowing). The ST said the resident was able to use less words and had expressed more frustration with her communication. The ST said Resident #46 was added to her caseload on 8/16/24 through 9/13/24. The ST said the resident had a generic communication board she received from the hospital but the resident did not respond well to it. She said created a new communication sheet/board using familiar phases and words the resident would use. The ST said she responded well to the new communication board and saw an improvement in her communication. She said she had not seen the staff use the communication board but figured it was somewhere in her room. The ST said the resident was still able to communicate a little when she was not agitated. The ST said Resident #46 was going to be added to her caseload again but was told the resident was possibly going to go on hospice so providing additional speech therapy was halted. The ST said the resident did not go on hospice services so she would request the resident to have speech therapy orders again. The ST said the facility had a lot of staff turnover which could have effected consistent communication with Resident #46 and the use of the communication board. She said once the resident was back on her caseload she would work with the resident again using the communication board. The ST said she could show the staff how to help the resident find her words. She said the use of purposeful sounds could also be effective in her communication. She said she could also educate the staff to anticipate Resident #46's needs and asked basic questions when the resident was agitated. The ST said there was an opportunity to educate staff and improve the resident's communication. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 12/10/24 at 1:02 p.m. The DOR said the resident required wheelchair assistance and did not self propel her own wheelchair. She said the staff should have listened to the resident as they transported the resident to the dining room on 12/4/24, when the resident expressed there was a problem. LPN #2 was interviewed again on 12/10/24 at 10:44 a.m. LPN #2 said he had been Resident #46's nurse for the past five weeks and was not aware of a communication sheet for her. The ST was interviewed again on 12/10/24 at 1:12 p.m. The ST said a communication sheet was laminated and added to the back of the resident's wheelchair on 12/10/24 (during the survey). She said she was going to do one to one education with the staff to show them how to use it. The ST said CNA #5 was aware of the communication board and knew where it was. She said CNA #5 found the board attached to a pink clip board and on her dresser covered with other items. The ST said some of the other staff may not have known where the board was and it was not readily in view. She said the staff should use the communication board/sheet when they tried to communicate with her. The ST said there had not been a consistent way to communicate with the nursing staff. She said sometimes she would speak directly to them or she would post a sign on the wall in a resident's room but the signage was not always welcomed. She said there had been a breakdown in communication with nursing staff and saw it as an area where improvements could be made. The ST said she would ask the NHA and the DON how they would like to implement the staff education related to communication with Resident #46. The ST said she was not familiar with the care plan process but the communication board/sheet should be added to make sure all staff were on the same page, improved communication for the resident and between the departments and decrease the resident's frustration when trying to communicate with staff. The ST said Resident #46 received new physicians orders for speech therapy as of 12/10/24 (during the survey). CNA #1 was interviewed on 12/10/24 at approximately 2:30 p.m. CNA #1 said Resident #46 had a communication sheet but she did not like it so staff stopped using it. The DON was interviewed again on 12/10/24 at 2:05 p.m. The DON said she was not informed that Resident #46 had a communication board. She said no one including the therapy department informed her of the communication board. She said when therapy had a new intervention, they would put in a request/verbal order and the DON would approve it. The DON said the therapy inventions could also be added to the care plan. She said when she was aware of the therapy intervention, the nursing staff could be educated on the intervention. The DON said there was a need to improve communication between therapists and the nursing department. She said the staff should come together and determine how to communicate with Resident #46, create a plan and add it to the care plan.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to ensure each resident had the right to formulate an advanced directive for one (#8) of four residents out of 28 sample residents. Specifically, the facility failed to ensure Resident #8's proxy selected or refused life-saving treatments within the power of a proxy. Findings include: I. Medical Orders for Scope of Treatment (MOST) form The MOST form documented that a Proxy-by-Statute (decision maker selected through a proxy process) may not decline artificial nutrition or hydration for an incapacitated resident without an attending physician and a second physician trained in neurology who certified that artificial nutrition or hydration would merely prolong the act of dying and was unlikely to result in the restoration of the resident to independent neurological functioning. II. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included stage 3 chronic kidney disease, hemiplegia affecting right dominant side (paralysis on one side of the body), expressive language disorder, aphasia (difficulty understanding and speaking) following a cerebral infarction (stroke) and schizotypal disorder (personality disorder). The [DATE] minimum data set (MDS) assessment revealed Resident #8 had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. III. Record review A proxy selection document, completed on [DATE], revealed that Resident #8 lacked decision-making capacity and had a proxy appointed. Resident #8's MOST form, reviewed on [DATE], documented the resident was a do-not-resuscitate (DNR), indicating the resident did not want cardiopulmonary resuscitation (CPR). Resident #8's MOST form was completed by his proxy and the proxy declined artificial nutrition on [DATE]. -However, the facility failed to have a physician's note signed by the resident's physician and a neurologist declaring the artificial nutrition was only prolonging death, as was required and instructed on the MOST form (see above). A quarterly social services evaluation, completed on [DATE], documented Resident #8 had a code status of DNR. Resident #8 was documented as his own decision-maker and had a severe cognitive impairment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, according to the [DATE] proxy selection document, Resident #8 lacked decision-making capacity (see above). IV. Staff interviews The business office manager (BOM) and the nursing home administrator (NHA) were interviewed together on [DATE] at 10:00 a.m. The NHA said she was unaware of what a proxy could approve or deny on the MOST form. The BOM said she was unaware of what the difference between a proxy and a medical durable power of attorney (MDPOA) was. The social services director (SSD) was interviewed on [DATE] at 10:05 a.m. The SSD said she reviewed MOST forms and ensured the forms were signed by the physician. The SSD said she had not read the back of the MOST form and was unaware a proxy was unable to decline artificial nutrition on the MOST form. The NHA was interviewed again on [DATE] at 10:30 a.m. The NHA said she was provided information that a proxy was able to refuse artificial nutrition on the MOST form ahead of time as long as when the time came to needing artificial nutrition, the proxy reviewed it with the resident's physician. The NHA said if a resident went to the hospital, the hospital provided treatment based on the MOST form and she saw it was an issue where the hospital probably would not provide the resident with nutrition. The director of nursing (DON) was interviewed on [DATE] at 4:11 p.m. The DON said the SSD trained her on the MOST forms and the DON then trained the nurses. The DON said she had not read the back of the MOST form and was unaware a proxy had different decision-making capabilities than a medical durable power of attorney (MDPOA).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for two (#18 and #39) of four residents out of 28 sample residents. Specifically, the facility failed to: -Identify the staff were using clothing to restrain Resident #18; and, -Ensure Resident #39 had a physician's order for a wander guard restraint. Findings include: I. Facility policy and procedure The Physical Restraint Management policy, revised 9/30/23, was provided by the nursing home administrator (NHA) on 12/10/24 at 1:30 p.m. It read in pertinent part, Physical restraints shall only be used for the safety and wellbeing of resident(s) and only after other alternatives have been tried unsuccessfully. Residents shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls. Any resident requiring a restraint will have a current physician order with the following components: the specific reason for the restraint (as it relates to the resident's medical symptoms device is to be used for), how and when the device is to be used to benefit the resident's medical symptoms and the type of restraint and period of time for the use of the restraint. The Resident Rights policy, revised February 2021, was provided by the NHA on 12/10/24 at 1:30 p.m. It read in pertinent part, Employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -A dignified existence; -Be treated with respect, kindness and dignity; -Be free from corporal punishment or involuntary seclusion and physical or chemical restraints not required to treat the resident's symptoms; and, -Privacy and confidentiality. II. Resident #18 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included dementia, Alzheimer's disease with late onset and need for assistance with personal care. The 11/14/24 minimum data set (MDS) assessment revealed Resident #18 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. Resident #18 required substantial/maximal assistance with upper body dressing. Resident #18 had no behavioral symptoms and had a wandering device restriction documented. B. Observations At 1:28 p.m. an unidentified staff member walked through the common area and saw Resident #18 without his shirt on. The staff offered to assist the resident and she put his shirt back on. At 1:35 p.m. Resident #18 was observed in a clean shirt with a pair of overalls on. C. Record review Resident #18's care plan, revised on 11/14/24, revealed the resident often took his shirt off in common areas. The intervention was documented as assisting the resident with putting on a clean shirt if he removed his shirt. -Review of Resident #18's electronic medical record (EMR) revealed an assessment and consent for Resident #18's wander guard and not the use of overalls or two shirts to prevent the resident from taking off his clothes. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 12/10/24 at 12:05 p.m. LPN #1 said Resident #18 removed his shirt in the common areas numerous times every day. LPN #1 said she did not know why the resident removed his shirt. She said the staff tried to redirect the resident to put his shirt back on but he usually removed his shirt anyway. LPN #1 said when Resident #18 removed his shirt, the staff took him to his room and placed two shirts on him or a shirt and overalls to prevent him from taking off his shirt around other residents. LPN #1 said the overalls restricted the resident the best and he was unable to remove his shirt. Certified nurse aide (CNA) #1 was interviewed on 12/10/24 at 1:59 p.m. CNA #1 said Resident #18 always removed his shirt and the staff were unable to figure out why. CNA #1 said when he saw Resident #18 without his shirt on he assisted the resident with putting it back on. He said other staff placed the resident in two shirts or a shirt and overalls. CNA #1 said it was not necessarily to restrain the resident but the idea was to make it harder for the resident to remove his shirt. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 12/10/24 at 4:11 p.m. The DON said Resident #18 constantly removed his shirt. She said she asked the resident if he was hot, cold, itchy or uncomfortable and the resident was unable to answer. She said the staff assisted the resident with putting his shirt back on or getting a clean shirt. She said the staff were not supposed to place him in two shirts or a shirt and overalls to restrict or restrain the resident from undressing. The DON said Resident #18 liked wearing overalls because he was a farmer when he worked but the staff were not to use the clothing as a restraint. III. Resident #39 A. Resident status Resident #39, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included frontotemporal neurocognitive disorder (brain disorder), dementia, senile degeneration of brain (progressive neurological disorder) and anxiety. The 10/16/24 MDS assessment revealed Resident #39 had long and short-term memory problems and her daily decision-making skills were severely impaired per staff assessment. Resident #39 needed supervision or touching assistance with getting dressed, showering and putting on footwear. He required partial/moderate assistance with toileting. He required set up or clean up assistance with oral hygiene and was independent with eating. The assessment indicated Resident #39 used a wander or elopement alarm daily. B. Record review A review of the December 2024 CPO revealed the following physician's orders: Signaling device (wander guard) to be monitored according to the manufacturer's recommendations and as needed to ensure the device functioned properly and to notify the DON if Resident #39's wander guard malfunctioned, ordered on 10/3/24. Assess Resident #39's skin to the right wrist twice a day where the wander guard was placed and staff to notify the provider of any skin changes, ordered on 10/12/24. -The facility failed to have a physician's order for the wander guard device that included the specific reason for the restraint (as it related to the resident's medical symptoms the device was to be used for), how and when the device was to be used to benefit the resident's medical symptoms and the type of restraint and period of time for the use of the restraint. -A review of Resident #39's EMR did not reveal documentation that the facility attempted a less restrictive intervention than the wander guard. C. Staff interviews LPN #1 was interviewed on 12/10/24 at 12:05 p.m. LPN #1 said Resident #39 was not using a restraint. She said she was not aware the wander guard was a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 12/10/24 at 4:11 p.m. The DON said the physician's orders entered for Resident #39 on 10/3/24 and 10/14/24 were not the orders for the restraint itself but for maintenance of the restraint once it was in place. The DON said a physician's order was going to be obtained for the wander guard and documented in the resident's chart on 12/10/24.

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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** 50314 Based on observation and interviews, the facility failed to ensure residents received professional standards of care for one (#48) resident reviewed for ileostomy care out of 28 sample residents. Specifically, the facility failed to: -Provide appropriate ileostomy care in a timely manner, which caused Resident #48 to develop dermatitis to the skin surrounding his ileostomy; and, -Failed to obtain physician's orders timely for Resident 48's ileostomy care. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 2554, retrieved on 12/14/24, Preserving peristomal (the skin around an ostomy) skin is critical because skin excoriation may cause an ineffective seal between the wafer and the skin and leakage of effluent. This in turn causes more skin and tissue damage. Leakage may indicate the need for a different type of pouch system or sealant. Pouches are usually changed every three to five days, preferable before leakage occurs. To decrease skin irritation, avoid changing the entire system. In a one or two piece pouching system, change the skin barrier only every three to seven days, never daily. II. Facility policy and procedure The Colostomy/Ileostomy care policy, revised October 2010, was provided by the nursing home administrator (NHA) on 12/10/24 at 5:52 p.m. It documented in pertinent part, The purpose of this procedure is the provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. When evaluating the condition of the resident's skin, note the following: breaks in the skin, excoriation, and signs of infection. Notify the supervisor of any abnormal findings (i.e. breaks in skin, excoriation, signs of infection) III. Resident #48 A. Resident status (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #48, over the age of 65, was admitted on [DATE] and discharged on [DATE]. According to the November 2024 computerized physician order (CPO), diagnoses included dehiscence of the gastrointestinal tract with surgical ileostomy placement, chronic obstructive pulmonary disease (COPD) and respiratory failure. According to the 10/29/24 minimum data set (MDS) assessment, Resident #48 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The assessment documented Resident #48 had no rejections of care. The assessment documented the resident had major surgery in the 100 days prior to admission to the facility. The assessment documented the resident's surgery required skilled nursing facility care. The assessment documented the resident had a surgical wound that required surgical wound care at the facility. B. Record review The hospital discharge instructions, dated 10/25/24, documented Resident #48 had an ileostomy placed during the hospital stay. The discharge instructions documented Resident #48 should go to the emergency room if his skin or site of infection was not getting better or looked different or worse, or if his wound is red, painful or smelled. Nursing progress note, dated 11/9/24, documented Resident #48's ileostomy bag was leaking again. The progress note documented Resident #48's peristomal skin was very red, sweating, and had dots of blood present after cleansing the skin. -The facility failed to prevent exposure of fecal matter to Resident #48's skin which caused Resident #48 to develop dermatitis of the skin. Skilled nursing progress note dated 11/9/24 at 5:08 a.m. documented that Resident #48's ileostomy bag was changed multiple times during the shift. The note documented Resident #48 felt upset that the ileostomy bag was not staying sealed. -However, ileostomy bags should never be changed more frequently than every three to five days. (see professional reference above) Mental health provider note, dated 11/9/24 at 11:19 a.m., documented Resident #48's family requested for Resident #48 to be sent to the hospital because his ileostomy bag was constantly leaking. The note documented Resident #48 and his family expressed concerns that Resident #48 was developing an infection transferring between the ileostomy bag and the abdominal dressing with the wound vac. The note documented the director of nursing (DON) was notified and Resident #48 consented to be transported to the hospital. Nursing progress note, dated 11/9/24 at 3:59 p.m., documented Resident #48 arrived back at the facility in good spirits with a new ileostomy bag. The note documented Resident #48 had been diagnosed by MD #4 to have dermatitis of the skin caused by a leaking ileostomy bag. -The facility failed to prevent exposure of fecal matter to Resident #48's skin which caused Resident #48 to develop dermatitis of the skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skilled nursing progress note, dated 11/10/24, documented Resident #48's wound dressing was changed multiple times. The progress note documented Resident #48's skin was red, sweating, and bled after being cleansed. -The facility failed to prevent liquid stool from causing dermatitis to the skin between the ileostomy and the midline abdominal wound. Alert progress note, dated 11/11/24, documented Resident #48 had dermatitis to his ostomy site which was currently being treated by being left open to air. The note documented the ostomy site was being cleansed with warm water and pat dry, placing a dry towel over the ostomy site to absorb any liquid stool. -The facility failed to assist Resident #48 to apply an ileostomy bag, which allowed liquid stool from the ileostomy to be uncontained. -The facility failed to obtain a physician's order to leave Resident #48's ileostomy open to air. Skilled nursing note, dated 11/11/24 at 11:04 p.m,. documented =Resident #48's ileostomy had dermatitis to the surrounding skin,and was being treated by cleaning with a warm washcloth and placing a dry washcloth over the ileostomy to absorb any liquid stool. The ostomy clinic initial evaluation, dated 11/13/24, documented Resident #48 was being evaluated in the clinic for ostomy appliance management. The documentation included Resident #48's statement that the facility had been caring for his ileostomy and they had been unable to get any appliance to adhere to his skin. Resident #48 said the facility had been leaving his ileostomy open to air without any appliance on it at all and had been applying Neosporin (antibiotic ointment) to his reddened skin around the ileostomy. Resident #48 said the facility had been cleansing his skin with warm water and towels every 15 minutes between 11/6/24 and 11/13/24. Resident #48 said he went to the emergency room over the weekend to have his ileostomy appliance evaluated as well. The ostomy clinic evaluation documented Resident #48 was alert and oriented to person, place, time, and situation. -A review of the November 2024 CPO did not reveal a physician's order for the nurses to apply Neosporin to the resident's skin around the ileostomy. The ostomy clinic physical exam documented Resident #48's peristomal (skin around the resident's ileostomy) skin condition had irritant contact dermatitis related to liquid stool. The physical exam documented Resident #48's skin was red, raw, open circumferentially around the stoma and had a widespread fungal rash. The ostomy clinic assessment documented Resident #48 arrived with no ostomy device in place. The clinic assessment documented facial tissues were stuck to the stoma and Resident #48 had stool leakage on his pants. The assessment documented the ostomy clinic gave Resident #48 new pants to wear home. The assessment documented Resident #48's wound vac device had failed because stool had gotten underneath the wound vac device. The assessment documented Resident #48's wound vac was also removed during the clinic evaluation and Resident #48's midline incision was soaked and treated before replacing the dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ostomy clinic documented nystatin powder (used to treat fungal infections) was applied and rubbed into the peristomal skin which contained a fungal rash. The ostomy clinic documented pictures and serial numbers of all cremes and devices used to replace Resident #48's ileostomy device in the wound clinic evaluation and treatment. The documentation included pictured nursing instructions of how to clean and replace Resident #48's ileostomy device. The ostomy clinic documentation included that it discussed the case with the DON on 11/13/24. The ostomy clinic documented that they told the DON what devices to order, and that it would fax the facility its recommendations for care including step-by-step instructions. Skilled nursing note dated 11/13/24 at 11:01 p.m. documented that Resident #48's ileostomy bag had been changed earlier that day at his appointment. Nursing progress note, dated 11/22/24, documented Resident #48 had been discharged home with home health services. The note documented Resident #48 and his family had received colostomy care education. Review of the November 2024 CPO included the following orders: Ileostomy directions, please follow instructions on paper in the cart. This was ordered on 11/14/24 and was active until the resident was discharged on [DATE]. -The facility failed to prevent the progression of the midline abdominal wound which now required a wet to dry dressing and was caused by exposure to liquid stool from Resident #48's ileostomy. -The facility failed to obtain physician's orders for Resident #48's ileostomy care before 11/14/24. IV. Staff interviews Registered nurse (RN) #1 was interviewed on 12/9/24 at 3:45 p.m. RN #1 said she remembered Resident #48 when he was admitted to the facility. RN #1 said the facility had ileostomy supplies. RN #1 said Resident #48's ileostomy was often leaking. RN #1 said Resident #48's ileostomy was left open to air for about a day. RN #1 said Resident #48's ileostomy was a difficult case for the facility. RN #1 said Resident #48's wife and the wound clinic supplied Resident #48's ileostomy supplies after his wound clinic visit. RN #1 said when Resident #48 was discharged he was still using the supply of ileostomy supplies the wound clinic had provided him. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 12/9/24 at 4:59 p.m. RN #2 said she was the home health nurse that was supposed to admit Resident #48 to home health services on 11/22/24 after he discharged from the facility. RN #2 said when she arrived at the resident's home, Resident #48 only had one spare ileostomy wafer left from the supply provided by the wound clinic on 11/13/24. RN #2 said Resident #48's wife reported that Resident #48 had become increasingly short of breath and had passed out that day when going upstairs. RN #2 said when she first looked at Resident #48's ileostomy, the ileostomy pouch was actively leaking. RN #2 said she and Resident #48's wife attempted to replace the ileostomy pouch and wafer, but were both unsuccessful. RN #2 said she felt uncomfortable about how Resident #48 looked upon assessment that she did not admit him to home health services and recommended that Resident #48 go to the emergency room . RN #2 said Resident #48 and his wife decided to call an ambulance and go to the emergency room . The DON was interviewed on 12/10/24 at 2:49 p.m. The DON said when a resident was seen at the wound clinic and received new orders, those orders were entered into the CPO and central supply ordered the necessary supplies. The DON said if a resident received a physician's order for a specialty product by the wound clinic, then she would review her available vendors to see if she can order the recommended item or a reasonable substitute. The DON said a resident's ileostomy should never be left open to air and nursing staff cannot leave an ileostomy open to air without a physician's order. The DON said if an ileostomy was left open to air, then the skin around the ileostomy could become infected or develop dermatitis. The DON said that dermatitis of the skin was painful and uncomfortable. The DON said Resident #48's ileostomy was difficult for the nursing staff to fit an appliance. The DON said the facility had ordered ileostomy supplies after receiving recommendations from the wound clinic on 11/13/24, but the supplies had not arrived at the facility by the time the resident discharged on [DATE]. The DON said the specialty ileostomy supplies Resident #48 required took two to four weeks to arrive at the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to treat and prevent pressure injuries for two (#46 and #50) of six residents reviewed for pressure ulcers out of 28 sample residents. Resident #46, who was known to be at risk for pressure injuries, was admitted on [DATE]. The resident had diagnoses of dementia, cognitive communication deficit, chronic pain, and generalized muscle weakness. On 11/11/24, Resident #46 developed a facility-acquired stage 2 pressure injury to her sacrum, however, the facility did not initiate further pressure ulcer interventions on the resident's pressure ulcer prevention care plan once the stage 2 pressure injury was identified and did not update the care plan to include the new pressure injury. On 11/19/24, physician documentation indicated Resident #46's pressure wound had worsened to an unstageable pressure injury. Despite the worsening of the pressure injury, the facility failed to implement a low air loss pressure relieving mattress until 11/26/24, 15 days after the initial pressure ulcer was identified. Despite the worsening of the resident's pressure injury, the facility did not initiate Resident #46's pressure injury care plan, which identified the resident had an actual pressure injury, until 12/4/24, two weeks later. Furthermore, observations during the survey revealed the facility failed to ensure Resident #46's low air loss mattress was appropriately set to the correct firmness level, per the physician's orders. Due to the facility's failure to implement timely interventions to prevent the development of pressure injuries and the facility's failure to implement additional interventions following pressure injury development, Resident #46 developed a facility-acquired stage 2 pressure injury, which worsened to an unstageable pressure injury. Additionally, Resident #50, who was at risk for developing pressure injuries, was admitted on [DATE]. On 9/2/24, facility documentation indicated Resident #50 had a new pressure injury located on her left heel. On 9/3/24, the wound note identified the left heel wound as an unstageable pressure injury and further identified pressure relieving heel protector boots were to be worn by the resident. According to the resident's skin integrity care plan, pressure injury prevention interventions were not initiated until 9/2/24, after the resident's left heel wound was identified. Wound care documentation for September 2024, October 2024 and November 2024 revealed wound care treatments and wound care interventions were not documented as occurring on several occasions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observations during the survey revealed several occasions where Resident #50 was not wearing her pressure relieving heel protector boots. Due to the facility's failure to implement timely interventions to prevent the development of pressure injuries, Resident #50 developed a facility-acquired unstageable pressure injury to her left heel. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 12/16/24 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as' the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Ulcer policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 12/10/24 at 5:52 p.m. It documented in pertinent part, Protecting against the effects of pressure, friction, and shear: reduce pressure over bony prominences by offloading and positioning, develop turning and repositioning plans for residents in bed or the chair, and evaluate the need for a pressure-reducing mattress or overlay - check for bottoming out to ensure appropriateness of mattress choice. Develop a plan of care in conjunction with the multidisciplinary team based on the individual's goals. Evaluate the plan of care and provide revisions and updates as needed. Any changes in pressure injury condition should be reported to the physician. III. Resident #46 A. Resident status Resident #46, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included dementia, cognitive communication deficit, chronic pain, and generalized muscle weakness. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 9/3/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The assessment documented the resident was independent with eating, required set-up or clean-up assistance with oral hygiene, and required partial or moderate assistance with all other activities of daily living. The assessment documented the resident was independent when rolling left to right in bed and required moderate assistance when changing positions in bed. The assessment indicated the resident was at risk for pressure ulcers and did not have any skin conditions at the time of the assessment. The assessment indicated the resident did not have rejections of care. B. Resident observations On 12/9/24 at 10:03 a.m. Resident #46's wound care was observed with the director of nursing (DON) and licensed practical nurse (LPN) #4. The resident's sacrum had a large crater-like wound with a black scab at the medial base (towards the middle or center) of the wound. The skin around the wound was red and purple in color and extended approximately two centimeters (cm) around the outside of the open wound. The wound measured 6.0 cm long by 3.0 cm wide and 2.0 cm deep, per the DON's measurement. Additionally, the DON measured that the wound had 2.0 cm of tunneling (a channel or tunnel that extends into deeper tissue under the surface of the wound) at the 1:00 and 9:00 position within the wound. The DON cleansed the wound with wound cleanser, applied collagenase to the wound bed and then applied a foam dressing to cover the wound. During a continuous observation on 12/9/24, beginning at 2:24 p.m. and ending at 5:02 p.m., the following was observed: At 3:03 p.m. an unidentified male staff member entered Resident #46's room to assist the resident. At 3:06 p.m. LPN #2 entered and exited Resident #46's room. At 3:06 p.m. Resident #46's low air loss mattress was observed to be firm and taut. The mattress setting level was observed to be set at 400 firmness. -The facility failed to set Resident #46's mattress firmness level in accordance with physician's orders (see physician's order below). At 4:20 p.m. LPN #2 entered and exited Resident #46's room. At 5:02 p.m. LPN #2 again entered and exited Resident #46's room. At 5:02 p.m. Resident #46's mattress was observed to be firm and taut. The mattress setting level was observed to be set at 400 firmness. -The facility failed to set Resident #46's mattress firmness in accordance with physician's orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Ridge Health and Rehabilitation Center	1043 Ridge St Montrose, CO 81401

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/10/24 at 10:22 a.m. Resident #46's mattress was observed to be softer than observations on 12/9/24. The mattress setting level was observed to be set at 125 firmness. A piece of tape with a drawn arrow was on the mattress firmness setting dial to indicate the correct firmness level the mattress should be set at. C. Record review The pressure ulcer prevention plan of care, initiated 6/5/24 and revised 11/26/24, documented that Resident #46 had potential for pressure ulcer development because of her impaired mobility, incontinence and dementia. The care plan goal was to minimize Resident #46's risk of skin breakdown, redness or the development of blisters or discoloration. Interventions included encouraging Resident #46 to reposition herself in bed and to assist the resident when needed, utilizing a low air loss mattress on the resident's bed (initiated 11/26/24), a pressure reducing wheelchair cushion and conducting a weekly skin check by the nurse. -The facility failed to initiate the intervention of a low air loss mattress on the resident's bed until 11/26/24, 15 days after resident #46 was identified as having a stage 2 pressure ulcer and seven days after the initial pressure ulcer had worsened to an unstageable pressure ulcer The pressure ulcer plan of care, initiated 12/4/24 and revised 12/4/24, documented the resident had an unstageable pressure ulcer. Interventions included identifying possible causative factors and resolving them when possible, monitoring and documenting the pressure ulcer, encouraging good nutrition and hydration and following facility protocols for treatment. -The facility failed to initiate a pressure ulcer plan of care for the actual pressure ulcer until three weeks after Resident #46 was identified as having a facility-acquired stage 2 pressure ulcer and two weeks after the initial pressure ulcer worsened to an unstageable pressure ulcer. An encounter note, written by nurse practitioner (NP) #1 and dated 11/11/24, documented that Resident #46 had functional quadriplegia. The encounter note documented Resident #46 had a new pressure wound to the sacral region that was a stage 2 pressure wound. The note documented the resident's sacral region had been moist due to incontinence and resident immobility. The note documented the facility initiated a turning schedule and wound nurse rounding for the resident. A wound assessment report, written by medical doctor (MD) #1 and dated 11/19/24, documented that Resident #46 had an unstageable pressure ulcer on her sacrum measuring 2.5 cm) wide by 2 cm long and 0. 6 cm deep. MD #1 documented the periwound (the skin surrounding the wound) was fragile. -The facility failed to implement timely interventions to prevent Resident #46's facility acquired stage two pressure ulcer from progressing to an unstageable pressure ulcer. An encounter note, written by NP #1 and dated 11/22/24, documented that Resident #46 did not want to seek western medicine and wished to pursue a comfort-focused care approach. NP #1 documented that Resident #46 likely experienced several neurological events recently which had contributed to her decline. The note documented that Resident #46's decline was precipitous and unavoidable. A wound assessment report, written by MD #1 and dated 11/25/24, documented that Resident #46 had an unstageable pressure ulcer on her sacrum measuring 2.5 cm wide, 1.5 cm. long and 0.6 cm deep. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Braden Scale assessment (tool used for predicting pressure ulcer risk), dated 11/30/24, documented Resident #46 was at a moderate risk for developing a pressure injury.The assessment documented Resident #46 could make occasional slight changes in body or extremity position but was unable to make frequent changes independently. -However, the 9/3/24 MDS assessment documented that the resident required moderate assistance when changing positions in bed (see resident status above). A wound assessment report, documented by MD #1 and dated 12/3/24, documented that Resident #46 had an unstageable pressure ulcer on her sacrum measuring 4.8 cm wide, 1.5 cm. long and 0.6 cm deep. -The measurements of the wound indicated the wound had worsened. An encounter note, written by NP #1 and dated 12/5/24, documented that Resident #46 had a stage three pressure injury on her sacrum. -However, MD #1's 12/3/24 wound assessment note documented the resident's wound was an unstageable pressure ulcer. NP #1's 12/5/24 encounter note further documented that Resident #46's sacral wound had progressed. The note documented the wound was now reddened and full thickness with some eschar at the base. The note documented the area had been moist due to incontinence and immobility of the resident. The note documented the wound now required a wet-to-dry packing daily for the next seven days. The note documented NP #1 spoke with Resident #46's representative to clarify Resident #46's goals of care. The note documented the plan of care was to continue assisting Resident #46 with ADLs and to continue offering treatments to Resident #46. A review of Resident #46's December 2024 CPO revealed the following physician's orders for wound care: To pressure area on sacrum, cleanse area with wound cleanser, apply [collagenase] to wound bed, cover with dry dressing, change daily and as needed. Observe for abnormalities in wound bed, surrounding skin, or pain associated with wound. Must notify provider of abnormalities and document under progress notes, ordered 12/9/24. Low air mattress to bed. Set at 125 firmness. Check the mattress every shift for proper setting and function, ordered 11/25/24. E. Staff interviews (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 12/9/24 at 10:08 a.m. The DON said she performed wound care as the wound care nurse for the facility. The DON said she worked with MD #1, who was the wound care physician for the facility. The DON said Resident #46's pressure injury was facility-acquired after Resident #46 experienced a previous change in condition which made her more immobile in bed. The DON said Resident #46's pressure injury looked much worse today (12/9/24) than it did the previous week. The DON said she could not see bone in the wound bed, but there was eschar present in the base of the wound bed. The DON said even though Resident #46's wound was an unstageable pressure ulcer and she did not see bone, the wound appeared to be a stage four pressure wound to her. The DON said the wound physician would classify the wound as an unstageable pressure ulcer that was facility-acquired. The DON said that Resident #46's wound had last been evaluated by MD #1 on 12/3/24 and she would communicate with MD #1 regarding Resident #46's worsening pressure injury on 12/10/24 when he assessed the wound again via telehealth (video monitoring). The DON said the facility had been having difficulty getting a wound doctor to be present in the facility and the facility exclusively used telehealth services for wound care physician services. LPN #4 was interviewed on 12/9/24 at 12:21 p.m. LPN #4 said she had only visualized Resident #46's wound a few times. LPN #4 said Resident #46's wound on her sacrum looked much worse than previously. LPN #4 said she did not know what size the wound was, but she said she knew it was bigger than it had been the previous week. LPN #4 said Resident #46 was being turned every two hours with wedge pillows and had a low air loss mattress to prevent the worsening of the pressure ulcer. -However, the low air loss mattress was not set to the correct firmness level according to physician's orders (see observations above and interview below) MD #1 was interviewed on 12/9/24 at 12:59 p.m. MD #1 said Resident #46 was experiencing an expected decline. MD #1 said Resident #46 had a physician's order that she was experiencing unavoidable weight loss and this was contributing to the development of her pressure ulcer. MD #1 said Resident #46's pressure ulcer on her sacrum was facility-acquired. MD #1 said she did not know the facility had not initiated a plan of care for Resident #46's facility-acquired pressure ulcer until the pressure ulcer had progressed to an unstageable pressure ulcer. MD #1 said that the resident's pressure ulcer was unavoidable. -However, there was no documentation in Resident #46's electronic medical record (EMR) which indicated the pressure ulcer was unavoidable. Certified nursing aide (CNA) #4 was interviewed on 12/9/24 at 6:42 p.m. CNA #4 said she was comforting Resident #46 because it hurt her to sit up in bed to eat. CNA #4 said Resident #46 had to be sat up in bed so she would not choke when she ate, but she said the resident was hurting because of her pressure ulcer. The DON was interviewed again on 12/10/24 at 2:49 p.m. The DON said when a resident developed a pressure ulcer, the facility would complete a documented change of condition, notify the resident's representative and notify her. The DON said physician's orders should always be followed. The DON said Resident #46's bed firmness level had not been set correctly and she did not know how long the resident's bed firmness level was not set correctly. The DON said she noticed the bed appeared to be way too firm this morning (12/10/24), and she observed the firmness level setting to be at 400. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON said she lowered Resident #46's low air mattress firmness level and added a marker to indicate where the mattress's firmness dial should be set for Resident #46. The DON said it was not acceptable for Resident #46's mattress level firmness to be set at 400 when it should have been set at 125. The DON said she did not know if the mattress's firmness could have contributed to the worsening of Resident #46's pressure ulcer. 40467 IV. Resident #50 A. Resident status Resident #50, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified dementia, severe without behavioral disturbance, cognitive communication deficit, repeated falls, unsteadiness on feet, muscle weakness, lack in coordination, need for assistance with personal care and age-related osteoporosis without current pathological fracture. The 8/20/24 MDS assessment documented Resident #50 had moderate cognitive impairment with a BIMS score of nine out of 15. The resident used a walker and A wheelchair. The MDS assessment did not identify the resident had a rejection of care behaviors. The MDS assessment indicated Resident #50 was at risk for pressure ulcer development and had an unhealed pressure ulcer. B. Wound care observations and DON interview Resident #50's wound care was observed on 12/9/24 at 9:48 a.m. with the DON. Resident #50 was in bed. She was not wearing pressure relieving boots to protect her heels prior to the wound care. Resident #50 had a black scab covering her entire left heel. The wound measured 2.3 cm by 2.7 cm. The DON said the wound was getting better and smaller. The DON applied wound cleanser and betadyne to the wound and then left the wound open to air (OTA). After completing the wound care, the DON retrieved the resident's pressure relieving boots from her closet and offered them to the resident. Resident #50 allowed the DON to put the pressure relieving boots on her feet without resistance or need for encouragement. During a continuous observation on 12/9/24, beginning at 2:31 p.m. and ending at 4:19 p.m., the following was observed: At 2:31 p.m. Resident #50 was lying in bed on her left side. Resident #50's pressure relieving boots were on the resident's wheelchair instead of on the resident's feet. The resident's heels were not offloaded as she laid on her left side. At 2:58 p.m. the resident remained in the same position and her pressure relieving boots remained on her wheelchair. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 3:03 p.m. LPN #2 entered and exited Resident #50's room. The resident remained on her side without her heels offloaded and without her pressure relieving boots on. At 4:19 p.m. LPN #2 and certified nurse aide (CNA) #1 entered and exited the resident's room. Resident #50 remained on her side without her heels offloaded and her pressure relieving boots remained on her wheelchair. On 12/10/24 at 9:44 a.m. Resident #50 was in bed laying on her left side. Her pressure relieving boots were on her lounge chair next to her bed. The resident's heels were not offloaded. At 9:51 a.m. LPN #2 identified the pillow between the knees of Resident #50 was not floating her heels. LPN #2 pulled the pillow down and placed it under the resident's left foot. He did not offer to put the resident's pressure relieving boots on her feet. C. Record review The skin integrity care plan, revised 12/2/24, identified Resident #50 had a deep tissue injury to her heel related to immobility. Pertinent interventions, initiated 9/2/24, included encouraging the resident to reposition herself throughout the shift and assisting her as needed, utilizing pressure relieving devices/adaptive equipment/soft booties when appropriate to potential pressure areas, floating the resident's heels with pressure relieving heel protectors or pillows at all times and, if the resident refused, conferring with the resident, the interdisciplinary team (IDT) and family to determine the reason for the refusal, trying alternative methods to gain compliance and documenting the alternative methods. -The skin integrity care plan did not identify that Resident #50 refused the pressure relieving boots. The 9/2/24 nursing progress note documented Resident #50 had a new pressure injury to her left heel with new physician orders for betadine and pressure relieving boots when in bed. According to the note, the staff implemented pressure relieving measures and offloading as tolerated. The 9/3/24 weekly wound round note identified Resident #50's left heel pressure injury as unstageable, dark purple in color and fluid-filled. The unstageable pressure ulcer measured 3.5 cm by 4 cm. According to the note, the interventions were to reposition the resident every two hours, float her heels and apply pressure relieving boots. The note documented staff should reapply the pressure relieving boots after wound care treatment. The 9/18/24 wound physician note identified Resident #50's wound as a pressure-induced deep tissue damage of the left heel measuring 3 cm by 4 cm with a 100% eschar. The wound physician recommended the use of heel protectors. The 9/22/24 weekly wound note identified the resident's left heel wound as unstageable and documented it measured 2.5 cm by 3 cm. The 10/23/24 wound physician note identified Resident #50's wound as a pressure-induced deep tissue damage of the left heel measuring 2.3 cm by 3 cm with a 100% eschar. The wound physician recommended the use of heel protectors. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 11/26/24 weekly wound note documented the resident's left heel pressure ulcer measured 2 cm by 2.5 cm. According to the note, the resident was to have her heel pressure offloaded when she was in bed. The 12/2/24 weekly wound note, documented the unstageable pressure wound to Resident #50's left heel measured 2.2 cm by 2.1 cm. The 12/3/24 wound physician note, documented the left heel pressure injury had100% eschar and measured 2.1 cm by 2.4 cm. The wound physician recommended the resident wear heel protectors. -Review of Resident #50's September 2024 treatment administration record (TAR) revealed the intervention to reposition the resident frequently for comfort was not documented as occurring on 9/12/24 and 9/28/24 during the 6:00 p.m. to 6:00 a.m. shift. -The September 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 9/12/24 and 9/28/24. -Review of Resident #50's September 2024 TAR further revealed the intervention to float the resident's heels for pressure relief was additionally not documented as occurring on 9/12/24 and 9/28/24 during the 6:00 p.m. to 6:00 a.m. shift. -The September 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 9/12/24 and 9/28/24. -Review of Resident #50's October 2024 TAR revealed the resident's daily wound care was not documented on 10/7/24, 10/20/24, 10/23/24 and 10/26/24. -The October 2024 TAR did not identify the resident refused the wound care treatment or why the wound care was not provided as ordered on 10/7/24, 10/20/24, 10/23/24 and 10/26/24. -Additional review of Resident #50's October 2024 TAR revealed the intervention to reposition the resident frequently for comfort was not documented as occurring on 10/20/24 during the 6:00 a.m. to 6:00 p.m. shift. -The October 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 10/20/24. -Review of Resident #50's October 2024 TAR further revealed the intervention to float the resident's heels for pressure relief was additionally not documented as occurring on 10/20/24 during the 6:00 a.m. to 6:00 p.m. shift. -The October 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 10/20/24. -Review of Resident #50's November 2024 TAR revealed the resident's daily wound care was not documented on 11/12/24 and 11/26/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The November 2024 TAR did not identify the resident refused the wound care treatment or why the wound care was not provided as ordered on 11/12/24 and 11/26/24. -Additional review of Resident #50's November 2024 TAR revealed the intervention to reposition the resident frequently for comfort was not documented as occurring on 11/12/24 and 11/26/24 during the 6:00 a.m. to 6:00 p.m. shift. -The November 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 11/12/24 and 11/26/24. -Review of Resident #50's November 2024 TAR further revealed the intervention to float the resident's heels for pressure relief was additionally not documented as occurring on 11/12/24 and 11/26/24 during the 6:00 a.m. to 6:00 p.m. shift. -The November 2024 TAR did not identify the resident refused the intervention or why the intervention was not provided as ordered on 11/12/24 and 11/26/24. -Review of the CNA task sheet for floating the resident's heels, between 11/10/24 and 12/9/24, did not identify the resident refused to float her heels with either a pillow or pressure relieving boots. The CNA task sheet for floating the resident's heels identified the resident had her heels floated throughout the day on 12/9/24. -However observations did not identify the resident's heels were floated on the afternoon of 12/9/24 (see observations above). Review of Resident #50's progress notes between September 2024 and December 2024 did not identify the resident refused the pressure relieving boots. D. Staff interviews LPN #2 was interviewed on 12/10/24 at 9:45 a.m. LPN #2 said Resident #50 should have minimum pressure to her left heel. He said she spent most of her time in bed but would get up for dinner. He said she preferred to keep a pillow between her legs but she had pressure relieving boots she was supposed to wear to float her heels. He said staff attempted to reposition Resident #50 every two hours but she preferred to lay on her left side. He said she should probably have two pillows in bed with her, one to float her heels and one for her knees as was her preference. The DON was interviewed on 12/10/24 at 11:29 a.m. The DON said Resident #50 had a history of not wanting to reposition herself which resulted in multiple pressure ulcers. The DON said the resident's pressure ulcer was unstageable. She said the pressure injury to the resident's left heel started as a stage 2 pressure wound but became unstageable shortly after it developed. She said the pressure injury remained unstageable. She said the resident had pressure relieving boots available to her but the resident would refuse because the boots made her hot. -However, there was no documentation in the resident's electronic medical record (EMR) to indicate the resident refused to wear her pressure relieving boots (see record review above). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON said Resident #50 preferred to use a pillow in between her knees. She said staff should still continue to offer the pressure relieving boots to the resident and if she refused, it should be documented. She said the boots would protect and relieve more pressure from the heel then a pillow and the boots would have been more likely to stay in place once they were put on. The DON said staff should not mark that pressure relieving devices were in place when the intervention was not done. The DON said staff should document wound treatments daily or identify why something was not charted on the TAR. She said the staff should document the care they were providing to the resident and not document when the resident had not received the treatment.

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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** 48412 Based on observations, record review and interviews, the facility failed to provide adequate supervision during the use of assistive devices to keep residents free from safety hazards for five (#46, #28, #13, #32 and #50) of 12 residents out of 28 sample residents. Specifically, the facility failed to: -Consistently implement new and effective fall interventions in a timely manner for Resident #28, Resident #13, Resident #32 and Resident #50 after each fall; and, -Ensure Resident #46 had footrests on her wheelchair to prevent her foot from getting stuck while the staff pushed the wheelchair. Findings include: I. Fall failures for Resident #28, Resident #13, Resident #32 and Resident #50 A. Facility policy and procedure The Fall Management policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 12/10/24 at 1:30 p.m. It read in pertinent part, A fall risk evaluation will be completed within the first 24 hours following admission. Each resident will be reevaluated quarterly, annually and when a significant change occurs. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Please note interventions are to be reevaluated when a resident falls for efficacy. Educate and communicate implemented interventions to direct care staff via verbal report. Document in the electronic health record the resident's response to interventions and revise interventions if they are not successful. If a resident experiences a fall with head injury, the fall is unwitnessed or a resident self-reports a fall, neurological checks will be initiated. The facility will review all falls daily (Monday through Friday) during the morning quality assurance and performance improvement (QAPI) meeting. Monthly, the QAPI committee will review residents with falls for updated interventions and/or recommendations. Fall review will include the following: -Review the risk management incident to ensure complete and appropriate parties have been notified regarding the incident; -Review the interdisciplinary team (IDT) risk management to ensure complete and appropriate interventions have been implemented; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review that a care plan has been initiated; and, -Provide revisions to the plan of care as necessary after falls. B. Resident #28 1. Resident status Resident #28, age less than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included multiple sclerosis (autoimmune disease), a history of falling, dependence on a wheelchair and epilepsy. The 9/29/24 minimum data set (MDS) assessment revealed Resident #28 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident had no impairment in his lower extremities and used a wheelchair for mobility. The assessment indicated the resident had had two or more falls since his previous assessment. 2. Record review The fall care plan, initiated 10/25/19, revealed Resident #28 was a high fall risk due to exacerbation of multiple sclerosis. Resident #28 often crawled out of bed and chose to crawl in an attempt to meet his own needs instead of asking for help. The falls were identified as unavoidable due to the resident having poor cognition and poor impulse control despite multiple interventions in place. Interventions included encouraging the resident to go to the restroom before meals (initiated 5/6/24), anticipating the resident's needs and offering assistance to the bathroom (initiated 5/17/24, encouraging the resident to consume more fluids (initiated 6/7/24), adding anti-tipper devices to the resident's wheelchair (initiated 6/13/24, reviewing the resident's medications (initiated 7/29/24), strategically placing a soft touch call light in the resident's room (initiated 9/17/24) and activities staff to provide person-centered one-on-one activities for the resident (initiated 12/3/24). -The care plan documented the resident's falls were unavoidable due to the resident's poor cognition and poor impulse control, despite multiple interventions in place, however, Resident #28 had 18 falls from January 2024 to December 2024 and the facility failed to implement new fall interventions for 12 of those falls (see falls below). The 1/2/24 progress note revealed a certified nurse aide (CNA) notified the nurse that Resident #28 was found on the floor sitting cross-legged. The resident said he was looking for his remote control and sat down on the floor. The resident said he felt wobbly and he was unable to get back up. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 3/5/24 progress note revealed the nurse was notified Resident #28 was found on the floor on his buttocks with his legs out in front of him. The resident was found with no pants or shoes on, just socks. The resident said he was trying to go to the bathroom and he felt wobbly and fell on his knees then sat on his buttocks. No injuries were noted. (continued on next page)

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	065195	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Ridge Health and Rehabilitation Center	1043 Ridge St Montrose, CO 81401

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility failed to implement a new fall intervention after the resident's fall. The 3/20/24 progress note revealed the resident was found sitting cross-legged on the floor. The resident was unable to recall what happened. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 5/2/24 progress note revealed Resident #28 was found sitting on the floor under his sink. The resident said he slid down the wall because it was better than falling. No injuries were noted. On 5/6/24 Resident #28's fall care plan was updated with a new intervention for encouraging the resident to go to the restroom before meals. The 5/13/24 progress note revealed Resident #28 was found on the floor near his sink. He said he felt wobbly and hit his head on the grab bar near the sink. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 5/16/24 progress note revealed Resident #28 was found sitting on his floor cross-legged. The resident said he felt wobbly and slipped. No injuries were noted. On 5/17/24 Resident #28's fall care plan was updated with a new intervention for anticipating the resident's needs and offering assistance to the bathroom. The 6/6/24 progress note revealed Resident #28 was found sitting on the floor next to his bed. The resident was drowsy but was somewhat oriented. The resident said he passed out while he was self-transferring and woke up when his forehead hit the floor. The resident had an injury to the palm of his right hand. On 6/7/24 Resident #28's fall care plan was updated with a new intervention for encouraging the resident to consume more fluids. On 6/13/24 Resident #28's fall care plan was updated with a new intervention for anti-tippers to be added to his wheelchair. The 7/26/24 progress note revealed Resident #28 was found sitting on the floor cross-legged in the doorway to his bedroom. The resident said he sat down before he fell because he felt wobbly. No injuries were noted. On 7/29/24 Resident #28's fall care plan was updated with a new invention for reviewing the resident's medications. The 9/1/24 progress note revealed Resident #28 fell in the bathroom while he was self-transferring. The resident was noted to be barefoot and was not using an ambulatory device. The resident said he fell on his bottom in the bathroom and crawled to the side of his bed. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/16/24 progress note revealed Resident #28 self-reported a fall and was found sitting on his bed. The resident said he fell between his wheelchair and refrigerator and was able to pull himself back up. No injuries were noted. On 9/17/24 Resident #28's fall care plan was updated with a new intervention for strategically placing a soft touch call light in his room. The 10/14/24 progress note revealed Resident #28 was found on the floor between his nightstand and bed with his head resting on the heater vent. The resident said he rolled off his bed. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 11/18/24 progress note revealed Resident #28 was found on the floor between his bed and wheelchair. The resident said he was trying to get into his wheelchair. He had a 3 centimeter (cm) by 3 cm skin abrasion (scrape) on his upper left back. -The facility failed to implement a new fall intervention after the resident's fall. The 11/19/24 progress note revealed Resident #28 was assessed for a fall and no injuries were noted. -The facility failed to document the details of the fall or implement a new fall intervention after the resident's fall. The 11/20/24 progress note revealed Resident #28 was found sitting on the floor with his legs crossed. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. A second 11/20/24 progress note revealed Resident #28 was found on the floor right outside his room. The resident said he thought he hit his head. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 11/30/24 progress note revealed Resident #28 was found on the floor sitting on his buttocks on the fall mat with his back against the bed. The resident said he hit his forehead. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. The 12/2/24 progress note revealed Resident #28 was found cross-legged on the floor in between his bed and wheelchair on his buttocks. The resident said he was trying to get into bed and hit his head on the mattress. No injuries were noted. -The facility failed to implement a new fall intervention after the resident's fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/3/24 progress note revealed Resident #28 was found cross-legged on the floor in between his bed and wheelchair on his buttocks. The resident's wheelchair's brakes were engaged and the wheelchair was flipped on its side. The resident said he was trying to get into his wheelchair and he hit his left shoulder on the mattress. On 12/3/24 Resident #28's fall care plan was updated with a new intervention for activities to provide person-centered one-on-one activities for the resident. 3. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 12/10/24 at 12:05 p.m. LPN #1 said Resident #28 lacked decision-making capacity unless it was simple choice questions. She said the resident often self-transferred and fell a lot. LPN #1 said the resident's fall interventions were to have a floor mat placed by the bed, call light placed in his hand when he was in his room, educating the resident to call for assistance and trying to get the resident in his wheelchair before he sat up in bed. LPN #1 said when a resident fell the registered nurse (RN) had to assess the resident before he was moved and that LPNs did not update care plans after a fall. The director of nursing (DON) was interviewed on 12/10/24 at 4:11 p.m. The DON said Resident #28 fell a lot and the facility worked with the nurse practitioner (NP) to get laboratory (lab) work ordered. The neurologist said the resident was falling a lot because of his multiple sclerosis progressing. She said when a resident fell , the nurses entered a generalized intervention into the resident's care plan, then the IDT met and entered a more individualized intervention into the care plan. She said the interventions implemented depended on what the IDT felt would be effective in preventing falls. The DON said after falls, old interventions needed to be reviewed because if the intervention did not work, a new effective intervention was needed. She said Resident #28's current fall interventions were encouraging the resident to use the call light, anticipating his needs, encouraging the resident to wear non-skid socks and using grab bars. The DON said she was unaware Resident #28's care plan was not revised with new interventions after each fall. She said the resident's care plan should have been updated with new interventions instead of revising old interventions that were not effective. 50314 C. Resident #13 1. Resident Status Resident #13, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included end stage renal disease, bipolar disorder and anemia. The 10/18/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required supervision or touching assistance when bathing, set-up or clean-up assistance with personal hygiene, and was independent with all other activities of daily living (ADL). 2. Record review (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 risk care plan, initiated 4/23/24 and revised 6/21/24, documented that Resident #13 was at risk for falling because of problems with her balance. Interventions included ensuring the resident's call light was within reach, anticipating the resident's needs and that the resident should use a shower bench when in the shower. A nursing progress note, dated 5/10/24, documented that Resident #13 experienced an unwitnessed fall. The progress note documented nursing staff found the resident at 7:05 p.m. sitting on the floor of the bathroom. A fall record documentation form, dated 5/10/24, documented that Resident #13 received neurological assessments beginning at 7:05 p.m. The fall record documented that Resident #13 did not receive a neurological assessment at 8:20 p.m. on 5/10/24 because the resident was smoking. The fall record documented that Resident #13 did not receive neurological assessments at 9:20 p.m., 9:50 p. m., 10:50 p.m., or 11:50 p.m. on 5/10/24 because the resident was sleeping. -The facility failed to perform neurological assessments consistently for Resident #13. -The facility failed to implement a new fall intervention on Resident #13's care plan after the 5/10/24 fall. A change of condition progress note, dated 5/20/24, documented that Resident #13 had an unwitnessed fall. The progress note documented the DON and a CNA found Resident #13 on the floor of her bedroom. The progress note documented Resident #13 was not able to follow commands and was experiencing confusion. The progress note documented the DON told the nurse to call for an ambulance. The note documented Resident #13 was transported to the hospital by emergency medical services (EMS). -The facility failed to provide and document a neurological assessment after the resident fell and before EMS arrived at the facility (see interview below). -The facility failed to implement a new fall intervention on Resident #13's care plan after the 5/20/24 fall. D. Resident #32 1. Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), incomplete paraplegia and paranoid schizophrenia. The 8/27/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of nine out of 15. He required moderate assistance with lower body dressing and footwear, required supervision or touching assistance with personal hygiene and showering, required set-up or clean-up assistance with upper body dressing and toileting hygiene and was independent with eating and oral hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record Review The fall risk care plan, initiated 8/31/22 and revised 11/14/24, documented that Resident #32 was a fall risk because of his impaired mobility, poor safety awareness and medication use. Interventions included physical therapy evaluation for strengthening and transfer training, anticipating Resident #32's needs, ensuring the resident's call light was within reach and ensuring the resident was wearing appropriate footwear. The Morse Fall Risk Scale assessment, dated 5/13/23, documented Resident #32 was a high risk for falling with a score of 75. The fall risk assessment documented a score of 45 or above indicated a resident was a high risk for falling. The assessment documented Resident #32 had a history of falling previously and had an impaired gait. The assessment documented that Resident #32 overestimated or forgot his limits. A fall record documentation form, dated 11/14/24, documented that Resident #32 experienced an unwitnessed fall at 6:15 a.m. The form documented Resident #32 should receive a neurological assessment at 5:10 p.m, however, there was no documentation for the neurological assessment on the form. The form further documented Resident #32 did not receive a neurological assessment at 5:10 a.m. on 11/15/24 because the resident was sleeping. -The facility failed to perform neurological assessments consistently for Resident #32. E. Staff interviews RN #1 was interviewed on 12/9/24 at 3:45 p.m. RN #1 said if a resident experienced an unwitnessed fall, the resident must be assessed immediately by a nurse and neurological assessments should be performed per the neurological assessment form. RN #1 said the facility protocol for neurological assessments was printed on the paper where neurological assessments were documented. RN #1 said that it was never acceptable to skip a resident's neurological assessments. LPN #3 was interviewed on 12/9/24 at 4:24 p.m. LPN #3 said if a resident experienced an unwitnessed fall, the RN would assess the resident right away while the LPN or a CNA obtained vital signs for the resident. LPN #3 said the neurological assessments started immediately after a fall and were conducted according to the protocol on the neurological assessment form. LPN #3 said RNs must perform assessments in the facility. LPN #3 said residents who fell should have their care plans looked at to see if there was anything else that could be done to prevent a resident from falling again. The DON was interviewed on 12/10/24 at 2:49 p.m. The DON said she defined a fall as any unplanned descent to the floor. The DON said neurological assessments were performed immediately and according to the protocol on the neurological assessment documentation form. The DON said it was important to perform the neurological assessments per the protocol to ensure that residents did not have a delayed head injury or suffered trauma. The DON said it was not acceptable for bedside nursing staff to skip or miss a neurological assessment unless the resident refused the assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON reviewed neurological assessment documentation for Resident #13 and Resident #32. The DON said Resident #13 experienced an unwitnessed fall on 5/10/24 and neurological assessments were not completed appropriately. The DON said on 5/20/24 Resident #13 was sent to the hospital after an unwitnessed fall and she was present. The DON said she performed the neurological assessment before EMS arrived 10 minutes later, but she did not document that neurological assessment. The DON said she should have documented the neurological assessment she obtained because she was the RN working at the time and present in the resident's room. The DON said Resident #32's neurological checks were not appropriately completed after his unwitnessed fall on 11/14/24. The DON said if a resident experienced a fall, the resident's plan of care should be updated with new fall interventions. The DON said she preferred to implement an intervention immediately, if possible. She said the IDT would then review the fall and determine the root cause for the fall. The DON said the fall interventions implemented in the plan of care should closely match the reason for the fall. The DON reviewed Resident #13's plan of care. The DON said Resident #13's fall plan of care was not updated after she fell on [DATE] and 5/20/24. 40467 F. Resident #50 1. Resident status Resident #50, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified dementia, severe without behavioral disturbance, cognitive communication deficit, repeated falls, unsteadiness on feet, muscle weakness, lack in coordination, need for assistance with personal care and age-related osteoporosis without current pathological fracture. The 8/20/24 MDS assessment documented Resident #50 had moderate cognitive impairment with a BIMS score of nine out of 15. She did not have inattention, disorganized thinking or rejection of care behaviors. The resident required assistance with ADLs and used both a walker and a wheelchair for mobility According to the MDS assessment, Resident #50 had a history of falls in the past six months. 2. Resident observation During a continuous observation on 12/9/24, beginning at 2:33 p.m. and ending at 4:19 p.m., the following was observed: At 2:33 p.m. Resident #50 was asleep in bed and her call light cord was draped over her head board and the call light was lying on the floor on the back side of the head board. Resident #50's call light button was not within reach of the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:03 p.m. licensed practical nurse (LPN) #2 and a CNA #1 entered the resident's room and assisted Resident #50's roommate before exiting the room. Resident #50's call light remained draped over the head board of the resident's bed and remained out of reach after LPN #2 and CNA #1 exited the resident's room. At 3:50 p.m. an unidentified housekeeper exited Resident #50's room. The resident's call light cord was on the fall mat and not attached to the wall. The call light was not within reach of the resident and the call light was not operational. At 4:07 p.m. Resident #50's call light remained on the resident's fall mat with the cord pulled out of the wall. At 4:18 p.m. LPN #2 entered and exited the resident's room. The resident's call light remained on the floor after LPN #2 exited the room. At 4:19 PM LPN #2 and CNA #1 entered the resident's room and identified that the call light was not activated when the cord was pulled from the wall. LPN #2 and CNA #1 reattached the resident's call light to the wall prior to exiting the resident's room. On 12/10/24 at 9:53 a.m. the maintenance of director (MTD) was in Resident #50's room repairing the call light wall attachment from the day prior (see interview below). During a continuous observation on 12/10/24, beginning at 1:40 p.m. and ending at 2:31 p.m., the following was observed: At 1:40 p.m. Resident #50 was in bed. The call light was between the wall and the back side of the resident's bed. The call light was not within reach of the resident. At 1:42 p.m. LPN #2 retrieved the call light from the back side of the bed and placed it on the resident's bed within her reach. At 2:31 p.m. the call light was on the floor on the fall mat. The cord remained attached to the wall. 3. Record review The 8/16/24 nursing fall risk assessment identified Resident #50 was at high risk for falls. Resident #50's fall care plan, initiated 8/16/24 and revised 10/24/24, directed staff to ensure Resident #50's call light was within reach and encouraged the resident to use it for assistance as needed. According to the fall care plan, the resident needed prompt response to all requests for assistance. a. Fall with injury on 9/11/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/11/24 unwitnessed fall incident report documented Resident #50 had an unwitnessed fall on 9/11/24 at 6:05 a.m. The report identified a CNA informed the nurse during the nurse to nurse report that Resident #50 was found on the floor. The LPN and a RN entered the resident's room and observed the resident sitting on the floor with a pillow behind her back against the bed frame. According to the note, the resident could not say what happened other than to tell the staff to get her off the floor. The resident was assessed and did not have an injury as a result of the 9/11/24 fall. -The incident report did not identify if the resident's call light was turned on prior to the fall or if the resident's call light was within reach at the time of the fall. The 9/11/24 skilled nursing progress note indicated education was provided regarding the resident's call light usage. The resident did not have complaints of pain or discomfort noted after the fall. According to the note, the resident was awake in bed with her call light and fluids within reach. The note documented the resident called excessively once she was in bed. The 9/16/24 IDT risk management review note documented the resident had an unwitnessed fall on 9/11/24 at 6:05 p.m. The resident was found sitting on the floor sitting next to her bed with a pillow between herself and the bed. According to the note, the resident was currently working with therapy. The IDT note identified intentional rounding was put in place as an intervention after the resident fell . -The IDT risk management review note did not identify Resident #50 had a second fall on 9/13/24 (see below). b. Fall on 9/13/24 The 9/13/24 nursing progress note documented a CNA informed the nurse during the nurse to nurse report that Resident #50 was found on the floor at 3:46 a.m. The note identified the LPN and the RN entered the room and observed the resident sitting on the floor with a pillow behind her back against the bed frame. According to the note, the resident could not say what happened other than to tell the staff to get her off the floor. The note identified the resident was not injured as a result from the 9/13/24 fall. -The 9/13/24 nursing progress note identified Resident #50 fell in the exact same manner as the fall on 9/11/24. -The 9/13/24 progress note did not identify if the resident's call light was turned on prior to the fall or if the resident's call light was within reach at the time of the fall. The 9/14/24 at 5:03 a.m. nursing progress note documented Resident #50 did not complain of pain or discomfort and she was able to get herself out of bed. According to the note, Resident #50 used her call light frequently on night shift. c. Fall on 9/17/24 The 9/17/24 nursing progress note documented Resident #50 was observed sitting on the floor next to her bed when the nurse was making the rounds. The note identified the resident's call light was in reach at the time of the fall and there were no injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The progress note did not identify if the resident's call light was on at the time of the fall. The 9/17/24 unwitnessed fall incident report documented the fall occurred at 10:40 p.m. and the resident was not able to describe what happened. The 9/19/24 IDT note documented the IDT reviewed Resident #50's fall on 9/17/24. The note identified the resident was self transferring at the time of the fall. The note documented a perimeter defining mattress was placed on the resident's bed to help assist the resident identify the bed's perimeters. According to the note, staff would continue to provide the resident's fall interventions, including the use of a low bed and a fall mat on the floor and the continuation of therapy services. -The IDT note did not indicate the resident fell again the following day, on 9/18/24. d. Fall on 9/18/24 The 9/18/24 nursing progress note identified Resident #50 fell on [DATE] without injury. The note documented the resident wore non-skid socks and her walker was close to her at the time of the fall. According to the note, the resident said she was trying to get up. The resident was educated on the spot to call for assistance. -The progress note did not identify if the resident's call light was within her reach at the time of the resident's fall and did not identify if the call light was on at time of the fall. The 9/18/24 IDT risk management review note identified Resident #50 had a fall on 9/18/24 at 10:40 p.m. She had weakness and confusion and was found on the floor next to her bed -The note did not identify additional fall interventions put into place after the 9/18/24 fall. e. Fall on 9/24/24 The 9/24/24 nursing progress note indicated Resident #50 had another unwitnessed fall. The note identified a CNA found Resident #50 on the floor of her room. The note documented the nurse entered the room and saw the resident sitting on the floor with her head down next to the bed. The RN assessed the resident after the unwitnessed fall. According to the note, the resident's call light was within reach at the time of the fall and she was educated on the importance of using a call light to call for assistance when wanting to get up. The resident would be monitored for 72 hours after the 9/24/24 fall. The 9/25/24 IDT risk management review note identified Resident #50 was confused and attempted to self transfer from bed without calling for help on 9/24/24. The note directed staff to encourage the resident to spend time out of bed and engage in activities of choice. The resident continued with physical therapy for strengthening. The IDT note, dated 9/26/24, documented the fall on 9/24/24 was without injury and was caused by the resident's poor safety awareness. f. Fall on 9/27/24 (continued on next page)

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Elk Ridge Health and Rehabilitation Center	1043 Ridge St Montrose, CO 81401

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/27/24 nursing progress note , indicated Resident #50 had another unwitnessed fall. The note identified Resident #50 was found lying on the floor in her room by the DON on 9/27/24 at approximately 11:05 a.m. The resident did not have injuries as a result of the fall. According to the note, the resident did not remember what happened to cause the fall. The note documented the call light was within reach and the resident was encouraged to use the call light when she needed assistance. The note indicated the resident verbalized understanding. The 9/30/24 IDT risk management review note documented that staff placed signs in the resident's room that read call don't fall. g. Fall on 10/22/24 The 10/22/24 nursing progress note indicated Resident #50 had another unwitnessed fall. The note identified the resident was found on the floor in her room. The resident's call light was not on. According to the note, the resident was last seen propelling herself in her wheelchair toward her room. The resident was not able to say what happened other than she wanted to go to bed. The 10/23/24 IDT risk management review note documented the resident had another unwitnessed fall. The resident was not injured. The note identified the 10/22/24 fall occurred at 6:45 p.m. while she tried to get into her bed. According to the note, the staff needed to offer the resident assistance to go to bed directly after meals as was her usual preference. h. Fall on 10/25/24 The 10/25/24 nursing progress note indicated Resident #50 had another unwitnessed fall. The note identified the resident fell on the floor next to bed on after attempting to go to the restroom without assistance. The note revealed the call light was not within reach of the resident at the time of the fall. The 10/25/24 f incident report identified Resident #50 was found on the floor without injury on 10/25/24 at 6:50 p.m. with her head near her bed and her feet directed towards her roommate's bed. According to the incident report, the resident did not know what happened. i. Fall on 11/9/24 The 11/9/24 nursing progress note indicated Resident #50 fell on [DATE]. The note identified the resident's nurse was notified by another resident that Resident #50 had fallen. The nurse and a CNA found the resident on the floor of her room with her head pointed towards the window and her feet pointed towards the bed. The resident was lying on her right side. The resident said she wanted to go back to bed. According to the note, the resident was in her recliner prior to the fall. The note revealed the resident's call light was not within reach of the resident. The resident said she wanted to go back to bed. The call light was placed within the r[TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observation, record review and interviews, the facility failed to ensure two (#31 and #50) of four residents reviewed for nutrition out of 28 sample residents received the care and services necessary to meet their nutritional needs and maintain their highest level practicable physical well-being. Resident #31 was admitted to the facility for long-term care on 8/12/24 with diagnoses of hypertension (high blood pressure), depression and atrial fibrillation. Upon admission on 8/12/24, the resident weighed 120.8 lbs. On 10/17/24, Resident #31 weighed 94 pounds. Resident #31 lost 26.8 lbs (22.1%) in less than three months, which was considered severe. The facility implemented several nutritional interventions on 10/17/24 which included encouraging her family to bring in her favorite food items, that Resident #31 preferred sweet foods, and to provide assistance and cueing as needed, which did not assist Resident #31 to increase her weight. The facility implemented nutritional supplements on 11/1/24 which were occasionally accepted by Resident #31 and also did not increase Resident #31's weight. On 11/20/24, the resident weighed 82.8 pounds. Resident #31 lost 11.2 lbs (11.9%) in less than three months which was considered severe. Due to the facility's failure to effectively implement nutrition interventions timely, Resident #31's weight continued to decline. Additionally, Resident #50 was admitted to the facility on [DATE] with diagnoses of dementia and adult failure to thrive. Upon admission, the resident weighed 119.1 pounds (lbs). Resident #50 sustained 23.1 lbs (19.4%) weight change from 8/16/24 to 11/20/24, in three months, which was considered severe weight loss. On 8/29/24 Resident #50 had an order for a high calorie nutritional supplement (Mighty Shake). Progress notes and the medication administration record (MAR) identified the resident did not receive the nutritional supplement on two occasions because the supplement was not available. Resident #50 lost 7.4 lbs between 9/3/24 and 9/19/24, indicating a 6.18% weight change in two weeks. The new intervention to combat the weight loss was to offer her snacks between meals. The record review identified Resident #50 did not have a nutrition care plan until 10/24/24 and not until after the resident had lost 17.7 lbs with a 14.86% weight change. The review of Resident #50's weights identified potential weight inaccuracies related to large weight gains and a lack of timely and consistent reweighs after the resident had significant weight changes. Findings include: I. Facility policy and procedure (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Weight Management policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 12/10/24 at 5:52 p.m. It documented in pertinent part, Residents are monitored for weight change on a regular basis. Results are reviewed and analyzed by the facility for interventions as appropriate. Residents identified with weight change will be assessed by the interdisciplinary (IDT) team, and further interventions will be implemented to minimize the risk for further weight change where possible and to promote weight stability. Weigh all residents upon admission, then weekly or as indicated by physician orders. Document the results in the medical record. Residents with weight variance (loss or gain) are reweighed. Significant and severe weight variance is defined as 5% change in one month, 7.5% change in three months, or 10% change in six months. The IDT meets weekly to review residents with identified weight change, develops a plan, implements, evaluates, and re-evaluates interventions to minimize the risk for weight change. Nursing staff is to notify food and nutrition services and the registered dietician (RD) of a resident's weight change. The RD further assesses the resident to determine root cause of weight change and makes recommendations to reduce or stabilize the weight change. II. Resident #31 A. Resident status Resident #31, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included hypertension, depression and atrial fibrillation. The 11/12/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. The resident required substantial or maximum assistance with bathing, toileting hygiene, lower body dressing, and footwear. The resident required supervision with personal hygiene. The resident required set-up or clean-up assistance with oral hygiene. The assessment documented Resident #31 was able to eat independently with no assistance. -However, the facility documented that the resident required assistance or cueing on the nutritional plan of care. The assessment documented the resident was 60 inches (5 foot) tall. The assessment documented the resident weighed 88 lbs. The assessment documented the resident had experienced 10% or more weight loss in the last six months and was on a physician-prescribed weight loss regimen. B. Observations (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a continuous observation in the main dining hall on 12/4/24, beginning at 11:47 a.m. and ending at 12:11 p.m. the following was observed: At 11:56 a.m. Resident #31 received her plate of food which included meatloaf, a dinner roll and a cookie. At 11:58 a.m. Resident #31 was eating a cookie with both hands. An unidentified staff member encouraged her to eat several food options on her plate, which she refused. At 12:06 p.m., Resident #31 had eaten the entire cookie. The unidentified staff member offered an alternative meal option to Resident #31, which she refused. During a continuous observation on 12/9/24, beginning at 5:38 p.m. and ending at 6:43 p.m. the following was observed: At 6:09 p.m. Resident #31 was assisted to the dining room in her wheelchair by an unidentified staff member. At 6:21 p.m. Resident #31 received her plate of food which included shrimp alfredo, toast, peas, and a cookie. Resident #31 immediately picked up the cookie and began eating it. At 6:22 p.m. CNA #1 offered Resident #31 assistance with her meal. CNA #1 was observed to encourage the resident towards the other items on her plate, which Resident #31 refused. At 6:27 p.m., CNA #1 was observed to encourage Resident #31 to eat the other food items on her plate, which she refused. Resident #31 continued to eat the cookie which she held with both hands. At 6:31 p.m., Resident #31 finished eating the entire cookie. Resident #31 then laid her head back in her wheelchair and closed her eyes for several minutes. At 6:40 p.m., Resident #31 picked up her fork, moved the shrimp alfredo on her plate around with the fork, and then she set the fork back down on the table and closed her eyes. At 6:43, CNA #1 asked Resident #31 if she was done eating, which she affirmed. CNA #1 offered Resident #31 an alternative food option, which she refused. C. Record review The nutrition care plan, initiated on 8/12/24 and revised on 10/17/24, revealed a goal of maintaining Resident #31's weight through the review period. Interventions added on 10/17/24 included notifying the nursing staff that Resident #31 had always been a picky eater, Resident #31 preferred sweet foods, encouraging Resident #31's family to bring her favorite foods and providing Resident #31 with assistance and cueing as needed during meals. -A review of the comprehensive care plan revealed there were no new or revised interventions implemented after the resident sustained severe weight loss on 11/20/24. Resident #31's weights were documented in the electronic medical record (EMR) as follows: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 8/15/24, the resident weighed 120.8 lbs; -On 8/20/24, the resident weighed 122.4 lbs; -On 9/3/24, the resident weighed 120.8 lbs; -On 9/16/24, the resident weighed 119.7 lbs; -On 9/23/24, the resident weighed 119.2 lbs; -On 10/8/24, the resident weighed 94.6 lbs; -On 10/17/24, the resident weighed 94 lbs; -On 10/23/24, the resident weighed 94 lbs; -On 10/29/24, the resident weighed 92.6 lbs; -On 11/6/24, the resident weighed 87.8 lbs; -On 11/13/24, the resident weighed 84 lbs; and, -On 11/20/24, the resident weighed 82.8 lbs. -The resident lost 26.2 lbs (21.7%), from 9/3/24 to 10/18/24, in one month, which was considered severe. -The resident lost 11.2 lbs (11.9%) from 10/17/24 to 11/20/24, in one month, which was considered severe. -The resident lost 38 lbs (31.5%) from 8/15/24 to 11/20/24, in three months, which was considered severe. The food preferences documentation, dated 10/2/24, revealed Resident #31's favorite foods were sweets. The food and nutritional admission assessment, dated 8/22/24, documented Resident #31's admission body weight was 120.8 lbs. The assessment documented Resident #31's weight in the hospital before admission to the facility was 121 lbs. The assessment documented Resident #31 was not at risk for an altered nutrition or hydration status. The assessment documented it was okay to offer the resident smaller portions of food as regular portions may be overwhelming. It also documented the regular portions were providing more than her estimated needs. The quarterly nutritional assessment, dated 11/12/24, documented Resident #31's usual body weight was 112 lbs. The assessment documented Resident #31 had experienced significant weight loss since her admission to the facility. The assessment documented Resident #31 had a poor appetite. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-However, the facility failed to implement a person-centered nutrition intervention after Resident #31 was identified to have significant weight loss. The multidisciplinary care conference documentation, dated 11/19/24, revealed a care conference was held on 11/19/24 with the nurse, dietary staff, the MDS nurse, the social worker, a certified nurse aide (CNA), the activities department, the therapy department, medical records, the director of nursing (DON), the provider, the NHA, the resident and the resident's representative. The care conference documented the resident weighed 88 lbs and had lost five pounds in the last week. The care conference documented Resident #31 required cueing, encouragement and occasional assistance with dining. The care conference documented Resident #31's favorite foods were fresh fruit and ice cream. A review of the December 2024 CPO revealed the following physician's orders related to nutrition: Regular diet, regular texture, with regular or thin consistency, ordered on 8/12/24. Mighty shakes (frozen nutritional supplement) three times per day for weight maintenance, record percentage consumed, ordered on 11/1/24. Unavoidable weight loss due to chronic pain and age related adult failure to thrive. Please continue to encourage supplement and food intake and manage pain with medications and non-medication methods, ordered on 12/10/24 at 3:42 p.m (during the survey) by medical doctor (MD) #2. Nutritional supplement intake documentation was reviewed between 11/1/24 and 11/30/24. Out of 90 nutrition supplement intake opportunities, Resident #31 refused to consume the supplement on 15 occasions. The intake documentation revealed 28 occasions where Resident #31 consumed fifty percent or less of the nutritional supplement. The intake documentation included 45 occasions where Resident #31 consumed the entire nutritional supplement offered. Nutritional meal intake documentation was reviewed between 11/6/24 and 12/4/24. Of 85 meal opportunities in the review period, Resident #31 was documented to have refused four meals. The facility documented Resident #31 ate less than fifty percent of her meal on 52 occasions. The facility documented Resident #31 ate 75 to 100 percent of her meal on 12 occasions. CNA task response documentation of the assistance Resident #31 required to eat her meal was reviewed between 11/6/24 and 12/4/24. Of 85 meal opportunities in the review period, the facility documented Resident #31 ate 16 meals independently, five meals with set-up or clean-up assistance, 12 meals with supervision or touching assistance, three meals with moderate assistance, and Resident #31 was dependent on nursing staff to eat 26 meals. The facility documented 23 meals were not applicable. -However, the facility documented the resident was independent with eating on the MDS assessment (see above). D. Staff interviews CNA #1 was interviewed on 12/9/24 at 5:48 p.m. CNA #1 said Resident #31 often refused her meals. CNA #1 said Resident #31 usually ate a cookie or sweet dessert if that was offered to her, but getting her to eat more nutritious food had been difficult. CNA #1 said he felt Resident #31 mostly ate sweets and ignored other foods. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 12/9/24 at 4:24 p.m. LPN #3 said Resident #31 mostly refused to eat her meals, or would only choose to eat the dessert item. LPN #3 said Resident #31 loved to eat cookies. LPN #3 said the nursing staff tried to get Resident #31 to eat more nutritious foods but it had been difficult to convince her to eat more than dessert. The registered dietitian (RD) was interviewed on 12/10/24 at 12:01 p.m. The RD said she had been working in the facility for approximately 18 months. The RD said when a resident experienced weight loss, she would try to individualize the diet of the resident and utilize a food first approach which included giving the resident their favorite foods using sweet foods, salty foods and ethnic foods as examples. The RD said when a resident lost weight it could be difficult to determine the cause. She said she would review the resident's food preferences to see if the resident was refusing certain kinds of foods often. The RD said that the interdisciplinary (IDT) team reviewed residents experiencing weight loss weekly. The RD said residents who experienced weight loss should have their nutrition plans of care reviewed and updated. The RD said she thought Resident #31 was losing weight because she did not have a desire to eat. The RD said that one time Resident #31's family brought in her favorite chili recipe which the resident refused. The RD said she did not know if Resident #31's weight loss was unavoidable. -However, Resident #31 was observed to eat 100% of the offered dessert on 12/4/24 and 12/9/24. The DON was interviewed on 12/10/24 at 2:49 p.m. The DON said residents who experienced weight loss were reviewed weekly and nutritional interventions were implemented by the RD. The DON said if all possible interventions were in place, then the facility would reach out to the physician or the family to ask for more help. The DON said if a resident was only eating sweet foods but was experiencing weight loss, then the facility should offer the resident additional sweets to give them enough calories to eat. The DON said a review from the physician could also be helpful in determining root causes for the weight loss. The DON said she did not believe a physician review had occurred for Resident #31's weight loss. The DON said the facility could have done more to slow the progression of Resident #31's weight loss. 40467 III. Resident #50 A. Resident status Resident #50, age greater than 65, was admitted to the facility on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included unspecified dementia severe without behavioral disturbance, cognitive communication deficit, adult failure to thrive, pressure induced tissue damage to the left heel, muscle weakness and a need for assistance with personal care. The 10/10/24 minimum data set (MDS) assessment documented Resident #50 had moderate cognitive impairments with a BIMS score of nine out of 15. The MDS assessment did not identify the resident had a rejection of care behaviors. The MDS assessment did not indicate Resident #50 had weight loss prior to her admission to the facility. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	B. Observations During a continuous observation on 12/9/24, between 6:08 p.m. and 6:36 p.m. in the dining room. The following was observed: At 6:08 p.m. Resident #50 was assisted to the dining room for dinner. The resident was placed at the dining table with other residents who required assistance with eating. At 6:19 p.m. Resident #50 continued to wait for her meal to be served. Her tablemates had already been served and were eating their meals. Resident #50 proceeded to push herself away from the dining table in her wheelchair. An unidentified CNA encouraged her to return to the dining table. At 6:29 p.m. Resident #50 was served a pork chop cut in bite sized pieces, peas and garlic bread. The resident was not served pudding or ice cream as identified on her meal ticket and as a nutritional intervention (see interview below). -Resident #50 was the last to be served at her table and waited over 20 minutes before she was served. At 6:36 p.m. Resident #50 attempted to stand up from her wheelchair. The resident was assisted out of the dining room. The resident ate less than 25% of her meal. C. Record review The nutrition care plan, dated 10/24/24, documented Resident #50 had a nutritional problem or a potential for a nutritional problem related to leaving greater than 25% of meals uneaten, unintended weight loss, a body mass index (BMI) of 18% and an increased nutrient need to support wound healing. Interventions, initiated 10/24/24, directed the staff to encourage the resident to dine at the assistance/cue table; offer the resident gentle redirection to table with cues to eat and drink; monitor weights as ordered; provide and serve the resident her supplements as ordered to include Mighty Shake (frozen nutritional supplement) between meals, offer snacks between meals, and Juven twice a day (wound support supplement); provide and serve her diet as ordered; monitor intake and record every meal; and the registered dietitian (RD) to evaluate the resident and make diet change recommendations PRN (as needed). The nutrition care plan intervention, dated 11/7/24, indicated Resident #50 would consume food and fluids at desired pace and amount to her level of comfort. -The review of the nutritional care plan revealed the care plan was not created until 10/24/24, over a month since the resident was admitted to the facility and after the resident sustained a weight loss of 17.7 lbs (and a 14.86%) in just over two months. Resident #50's weights were documented in the resident's EMR as follows: -On 8/16/24, the resident weighed 119.1 lbs, obtained with a chair scale; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 9/3/24, the resident weighed 119.8 lbs, obtained with a chair scale; -On 9/19/24, the resident weighed 112.4 lbs, obtained with a wheelchair scale; -On 9/24/24, the resident weighed 104.4 lbs, this weight was struck out and indicated a reweigh was completed on 10/8/24; -On 10/2/24, the resident weighed 117.8 lbs, obtained with a standing scale; -On 10/8/24, the resident weighed 105.4 lbs, obtained with a wheelchair scale; -On 10/9/24, the resident weighed 103.6 lbs, obtained with a wheelchair scale; -On 10/23/24, the resident weighed 101.4 lbs, obtained with a wheelchair scale; -On 10/29/24, the resident weighed 102.4 lbs, obtained with a wheelchair scale; -On 11/6/24, the resident weighed 98 lbs, obtained with a wheelchair scale; -On 11/20/24, the resident weighed 96 lbs, obtained with a wheelchair scale; -On 11/27/24, the resident weighed 98 lbs, obtained with a wheelchair scale; and, -On 12/5/24, the resident weighed 99.8 lbs., obtained with a wheelchair scale. -The resident lost 14.7 lbs (12.3%) from 8/16/24 to 9/24/24, in one month, which was considered severe. -The resident lost 23.1 lbs (19.4%) from 8/16/24 to 11/20/24, in three months, which was considered severe. -The facility failed to reweigh the resident after a significant weight loss. The physician order, dated 8/16/24. identified Resident #50 had a regular texture diet. The food and nutrition assessment, dated 8/29/24, identified the RD met and observed Resident #50 eating breakfast in her room. The resident told the RD she had a good appetite, no mouth pain and no swallowing difficulties. According to the assessment, the RD discussed the role of good nutrition and wound healing with the resident. The assessment documented the resident ate on average 26% to 50% of her breakfast, 26% to 50% of her lunch and 50% to 75% of her dinner. The assessment documented the resident was at a healthy weight. (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 0692 Level of Harm - Actual harm Residents Affected - Few	malnourishment. According to the assessment, the resident had no weight loss in the last three months and ate about 75% of her meals. -However, a review of the resident's electronic medical record (EMR) identified the resident had lost weight in the past three months and ate less than 75% of her meals. The physician's order for mighty shakes, dated 10/31/24, identified the resident had an order for Mighty Shakes three times a day for weight maintenance, an increase from twice a day that was ordered on 8/29/24. The November 2024 and December 2024 (11/10/24 to 12/10/24) intake record for the amount of food the Resident #50 ate indicated she ate 13 meals at 75% to 100%; 46 meals at 51% to 75%; 22 meals at 26% to 50% and she ate 4 meals at 0% to 25%. According to the record, the resident ate 51% to 75% of her 12/9/24 dinner meal. -However, the resident was observed to have eaten less than 25% of her meal (see observation above). The food and nutrition progress note, dated 12/5/24, indicated the resident's weight was overall stable for the past 30 days. The note identified the resident refused two meals in a seven day look back, refused her house supplement twice since 12/1/24 and had an average meal intake of 50%. According to the note, the IDT would continue the current interventions, routinely monitor the resident's weight and meal and supplement intake and acceptance. An unavoidable weight loss order, dated 12/10/24 (during the survey period), was provided by corporate consultant (CC) #3 on 12/10/24 at 4:25 p.m. The order indicated Resident #50 had unavoidable weight loss due to her adult failure to thrive. The order directed the staff to encourage supplements and food intake using foods the resident preferred. -However, according to the physician orders and the review of the resident's EMR, the resident did not have unavoidable weight loss until 12/10/24, during the survey period, and after the registered dietitian identified Resident #50's weight was stable. The review of the EMR, observations and interviews identified opportunities that would have potentially prevented weight loss. A facility action plan for weight loss, dated 11/27/24, was provided by the nutritional CC #3. The action plan documented the facility had concerns with residents losing weight. The action plan identified new interventions to address the facility weight loss concern, According to the action plan, staff were to weigh the residents on Monday and Tuesday instead of any day of the week, supplemental shakes would be administered by the nurse on the floor, names of residents with weight loss were to be posted at the nurses station, a list of residents with supplement shakes were to be in the nurses book on the cart for easy access and the residents would be encouraged to eat meals in the dining room. D. Staff interviews (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	CC #3 was interviewed on 12/10/24 at 2:46 p.m. CC #3 said she was a nutrition resource to the facility when needed. She said the facility asked her in November 2024 to look at all the residents' nutritional needs. She said she reviewed the residents' nutritional needs and management and reported back to the facility who they should be focusing on. CC #3 said she identified Resident #50 had a calorie deficit and recommended the physician to identify if the resident had possible unavoidable weight loss due to her weight loss versus intake. The RD and CC #3 were interviewed on 12/10/24 at 2:54 p.m. The RD said she had been following Resident #50 weekly related to her weight loss and pressure injury. She said the staff had been trying to encourage the resident to eat in the dining room. The RD said the resident's meal intake varied whether she ate in the dining or in her room. She said the resident was placed at the meal assistance table in the dining room for meal intake encouragement, however if the staff cued the resident she could become frustrated which would be counter productive. The RD said she had had a difficult time obtaining the resident's food preferences. She said the resident was offered high calorie supplements but the resident's consumption of the supplements had been hit or miss. She said the resident received fortified food which could be butter or heavy cream. CC #3 said ice cream or pudding was added to the resident's meal ticket. The RD said she reviewed the resident's weights. She said she believed the wrong weight was stuck out in error. She said the 117.8 lb weight was probably not an accurate weight and the 104.4 lb weight should have been identified as the correct weight because the resident was not eating well. The RD said the facility needed to have the same staff weigh the resident using the same scale at the same time of day to determine an accurate weight. The RD said the resident had severe weight loss since her 8/16/24 admission but the facility was able to slow down the weight loss and put interventions in place. She confirmed the resident did not have a nutritional care plan until 10/24/24. She said the staff could review the physician orders to identify the interventions instead of a care plan. CC #3 said the interventions should have been on the care plan. CC #3 said the care plan needed to be improved. The RD said she had not identified the weight loss was unavoidable and did not believe the resident's physician identified the resident's weight to be unavoidable. She said the resident did not have orders for an unavoidable weight loss. She said the resident was currently maintaining her weight. The RD said she had identified some inaccuracy with the resident's weight record. She said the facility's assistant director of nursing (ADON) used to oversee the residents' weights and management but since she had the facility, the documentation had been inconsistent. She said weight management consistency could help accuracy of the nutrition program. CC #3 said Resident #50 had past trauma in her life and the facility needed to look at if the trauma could contribute to her weight loss. The CC said depression could contribute to the resident's weight loss. CC #3 was interviewed again on 12/10/24 at 3:42 p.m. CC #3 said Resident #50 should have been offered ice cream or pudding on 12/9/24 during the dinner meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 12/10/24 at 3:48 p.m. The DON said she was aware of the resident's weight loss. She said she accepted the supplement shakes but did not eat a lot. The DON said the mini nutritional assessment, dated 11/22/24 was inaccurate. She said the resident often ate less than 75% and had significant weight loss. She said the point of an accurate assessment was to capture weight loss. She said the staff had not had a recent education on how to identify meal percentages. She said the last time it was reviewed was during the July 2024 skills fair. The DON said the facility needed to have the same staff weigh the residents using the same scale each time to help with accuracy of weights. She said the facility started the process a couple a weeks ago (refer to the above 11/27/24 action plan). The DON said she was not sure why Resident #50 did not have a nutritional care plan until 10/24/24. The DON said the RD was responsible for creating the nutrition care plans but the facility should have identified the need for the care plan prior to 10/24/24 and after the resident's initial weight loss. The DON said adequate nutrition was important for a resident's overall health. The DON said a care plan was a care directive so staff knew to provide the recommended interventions. The DON said it was possible Resident #50's weight loss was not unavoidable. CC #3 was interviewed again on 12/10/24 at 4:24 p.m. CC #3 said the resident had an adult failure to thrive diagnosis that may have contributed to her weight loss but the facility had work to do related to weight management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50314 Based on record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to implement an effective water management plan. Findings include: I. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, last reviewed 3/15/24, was retrieved on 12/11/24 from https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html It read in pertinent part, Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (degrees Fahrenheit) or 60 C (degrees Celsius). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible. Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 F, 25-45 C). Legionella may grow at temperatures as low as 68 F (20 C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Legionella Water Management Program policy, undated, was provided by the nursing home administrator (NHA) on 12/5/24 at 10:14 a.m. It documented in pertinent part, Health care facilities have been connected with the transmission of legionella to patients. Such cases frequently arise due to the presence of legionella bacteria in facility hot water distribution systems. A number of preventative measures are available including maintenance of appropriate facility hot water temperatures to limit the growth of legionella. Flush unoccupied areas (hot and cold) monthly. -However, the CDC recommended that all dead legs and low flow piping runs should be flushed at least weekly to prevent the growth and spread of legionella (see professional reference above). C. Record Review The water safety plan workbook, not dated, was provided by the NHA on 12/5/24 at 10:14 a.m. The plan documented the facility did not test for legionella bacteria but instead utilized visual inspection and hot water flushing to prevent the growth and spread of legionella. The water management plan documented the facility had a kitchen water system, a main hot water system, a swamp cooler system, and a laundry hot water system. -The water management plan failed to include a process flow diagram of water systems in the facility. On 12/5/24 at 3:05 p.m., the NHA documented that five resident rooms had been unoccupied for seven contiguous days or more in the last 60 days. -The water management plan failed to document when empty resident rooms had low flow piping runs and lead legs flushed. D. Staff interviews The maintenance director (MTD) was interviewed on 12/5/24 at 2:37 p.m. The MTD said he utilized a combination of visual inspection and water temperature testing to prevent the growth and spread of legionella in the facility. The MTD said there was no documentation of process flow diagrams within the facility water management plan. The MTD said he did not know what a process flow diagram was. The MTD said he had not received education on how to complete a process flow diagram of water systems within the water management plan. The MTD said he was not involved in making the current water management plan for the facility. The MTD said the current water management plan which was not dated was completed before he started working at the facility in April 2024. The MTD said that the resources section of the water management plan could be outdated since many of the CDC resources were dated between 2003-2013, which was old information. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The MTD said all of the empty rooms in the facility had hot water run though all dead legs and low-flow piping runs of empty resident rooms in the facility every month. The MTD said that monthly flushing of resident rooms was sufficient to prevent the growth and spread of legionella. The MTD said the facility did not document when empty resident rooms were flushed with hot water to prevent the growth of legionella. The director of nursing (DON) was interviewed on 12/10/24 at 12:56 p.m. The DON said she also worked as the infection preventionist (IP) in the facility because the IP role was currently vacant. The DON said she was not directly involved in the water management plan because that was the responsibility of the maintenance department in the facility. The DON said she thought water had to be flushed daily to prevent the spread of waterborne pathogens such as legionella. The DON said she was not aware the facility practice was to flush water in empty resident rooms every month.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal and influenza vaccinations for one (#29) of five residents out of 28 sample residents. Specifically, the facility failed to offer the influenza and pneumococcal vaccinations to Resident #29. Findings include: I. Facility policy and procedure The Immunizations policy, dated 7/28/23, was provided by the social services director (SSD) on 12/4/24 at 11:44 a.m. It documented in pertinent part, Each resident will be offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The facility will determine whether or not a resident has received a pneumococcal immunization at the time of admission to the facility and again after age 65 if the resident ages in place to turn 65. Pneumococcal immunizations to be offered as indicated following CDC recommendations. II. Resident #29 A. Resident status Resident #29, over the age of 65, was admitted to the facility on [DATE] and readmitted [DATE]. According to the December 2024 CPO, diagnoses included dementia, diabetes mellitus, and depression. The 11/12/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. The assessment documented the resident had not received the influenza vaccine in the facility for this year's influenza season. The assessment documented the facility did not offer the influenza vaccine. The assessment documented that Resident #29's pneumococcal vaccination was not up to date, and the facility had not offered a pneumococcal vaccination to the resident. B. Record review The state immunization tracking documentation was provided by the director of nursing (DON) on 12/10/24 at 11:38 a.m. It documented that Resident #29 had not received a pneumococcal immunization previously and required a pneumococcal immunization. It documented that Resident #29 last received an influenza vaccination on 10/1/2020 and required an influenza vaccination. -The facility failed to offer Resident #29 a pneumococcal or influenza vaccination (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews The DON was interviewed on 12/10/24 at 12:56 p.m. The DON said that her normal process was to begin offering the influenza and pneumococcal vaccinations annually beginning in October. The DON said that Resident #29 had not been offered influenza vaccination or pneumococcal vaccination before 12/10/24 (during the survey) since he was admitted to the facility. The DON said Resident #29 should have been offered influenza and pneumococcal vaccinations earlier. The DON said that the facility would offer influenza and pneumococcal vaccinations to Resident #29 on 12/10/24.