STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065203	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherrelyn Healthcare Center	5555 S Elati St Littleton, CO 80120

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#35) of three residents reviewed for activities out of 59 sample residents received an ongoing program of activities designed to meet the needs and interests, and promote physical, medical and psychosocial well-being. Specifically, the facility failed to ensure Resident #35 was provided with one-to-one activities and invited to her preferred activities. Findings include: I. Facility policy and procedure The Activities Program policy and procedure, revised June 2018, was received from the director of nursing (DON) on 1/31/25 at 12:41 p.m. It revealed in pertinent part Activity programs are designed to meet the interests and support the physical. Mental and psychosocial well-being of each resident. Activities are offered based on the comprehensive resident-centered assessment and the preferences of each resident. Activities are considered any endeavor, other than routine activities of daily living (ADL), in which the resident participates. That intended to enhance his or her sense of well being and to promote or enhance physical, cognitive or emotional health. Our activities programs are designed to encourage maximum individual participation and are geared to the individual resident needs. All activities are documented in the resident's medical record. Residents are encouraged, but not required, to participate in scheduled activities. II. Resident #35 A. Resident status (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, type two diabetes mellitus, peripheral vascular disease (decrease in peripheral circulation), hypertension (increase in Blood pressure) and chronic kidney disease (decrease in kidney function). The 11/26/24 minimum data set (MDS) assessment revealed the resident had short and long term memory issues per staff assessment. She was dependent on staff for eating, toileting, dressing and transfers. The assessment indicated the resident did not reject care from staff. It revealed per staff assessment the resident enjoyed listening to music, being around animals, doing things with groups of people, participating in favorite activities, spending time outdoors and participating in religious activities. B. Observations On 1/27/25 at 11:58 a.m. Resident #35 was observed laying in her bed staring at the ceiling. On 1/28/25 at 2:00 p.m. Resident #35 was observed in her bed with the television on. Bingo was going on in the main dining room. Resident #35 was staring at the ceiling. During a continuous observation n 1/29/25, from 9:50 a.m. to 1:50 p.m., the following was observed:. At 9:50 a.m. Resident #35 remained in her room in bed with the television on. At 11:00 a.m. a scheduled music activity began in the main dining room. -Resident #35 was not approached by staff to see if she would like to attend the activity. The resident liked listening to music (see record review below). On 1/29/25 at 1:13 p.m. an unidentified certified nurse aid (CNA) entered the resident room with a lunch meal tray. CNA sat down and assisted the resident with eating but she did not converse with the resident during this time. -The unidentified CNA failed to converse with Resident #35 per interventions in the care plan (see record review below). C. Record review The 3/4/19 comprehensive care plan documented Resident #35 enjoyed programs with music. Resident #35 required reminders and assistance with transportation. The care plan identified goals that included Resident #35 would engage in sensory stimulating activities two to three times a week, Interventions included Resident #35 would be part of one-to-one therapeutic programs one to three times a week to help with loneliness, boredom and isolation. The care plan also identified that Resident #35 enjoyed sensory music, talking and did not enjoy being touched and could become agitated -However the staff interviews indicated the resident liked physical contact (see staff interviews below). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Life Loop activities documentation (12/30/24 to 1/30/25) was provided by the activities director (AD) on 1/30/25 at 9:50 a.m. revealed the resident had received one session of one-to-one activities. -Resident #35 was missing a minimum of three other one-to-one activities sessions in the past month. D. Staff interviews The activities assistant (AA) was interviewed on 1/30/25 at 9:20 a.m. The AA said residents were evaluated on their likes and dislikes upon admission. She said it was determined if the resident would benefit from one-to-one interactions from the activities department. She said the evaluation also helped the staff determine which activities the resident may want to join. The AA said if a resident received one-to-one visits the visit would be scheduled for two to three visits a week. The AA said she had worked with Resident #35 for a while and Resident #35 enjoyed talking, physical contact, being with others and loved music. The AA said Resident #35 attended group activities all of the time. The AD was interviewed On 1/30/25 at 9:28 a.m. The AD said one-to-one programs were resident specific and would vary on one to three visits a week. The AD said all residents were invited to activities throughout the day. The AD said if there was an activity that a resident really enjoyed, the activities staff would invite them and talk with the CNA to ensure they were assisted to attend. The AD said sometimes the staff had to ask the residents who had dementia several times to participate in the activity due to their memory issues. The AD said one-to-one interactions with residents were documented in a paper spread sheet then were added to life loop electronic documentations. The AD said Resident #35 was non verbal and liked music, smells and physical contact. The AD was interviewed again on 1/30/25 at 10:00 a.m. The AD said per documentation Resident #35 had only received one out of four one-to-one sessions in the past 30 days. The AD said maybe the session had not been documented yet by the assistants.The AD said if it was not documented then it did not happen since documentation was proof something had occurred.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain vision abilities for one (#1) of two residents reviewed for vision problems out of 59 sample residents. Specifically, the facility failed to provide Resident #1 assistance in getting new glasses. Findings include: I. Resident #1 A. Resident status Resident #1, age 68, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, type two diabetes and chronic obstructive pulmonary disease (COPD). The 10/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial/maximal assistance with toileting hygiene, showering/bathing, upper and lower body dressing and personal hygiene. The MDS assessment documented the resident had adequate vision with eye glasses. B. Resident interview Resident #1 was interviewed on 1/27/25 at 10:47 a.m. Resident #1 said he had his eye exam last year and was waiting for his glasses to come. He said that the facility had not assisted him with getting new glasses. He said he could not see out of his left eye and his right eye was blurry. He said he felt frustrated that he could not read his books. C. Record review The vision care plan, revised 9/11/24, documented Resident #1's wore glasses. It documented the resident preferred looking through his right eye. Pertinent interventions included for the staff to remain in line of sight, providing assistance to the resident if he needed help taking his glasses off, arranging vision care visits as needed and documenting any signs of eye problems. The 5/16/24 eye consult office visit revealed Resident #1 had an eye exam. The note included the resident's new prescription for eyeglasses. The note documented the resident was prescribed bifocal glasses. The note documented insurance would be billed accordingly. It indicated if there was no insurance coverage was available, the resident would be provided a separate invoice if they chose to purchase the eyeglasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating the resident had received his eye glasses. D. Staff interviews Social service (SS) #3 was interviewed on 1/30/25 at 11:26 a.m. SS #3 said she was responsible for arranging eye exams for the residents. SS #3 said the eye doctor was at the facility monthly. She said the residents should be seen by an eye doctor every three months. SS #3 said Resident #1 was seen by the eye doctor on 5/16/24 and he had Medicaid. SS #3 said Medicaid would pay for the glasses if the PETI (post-eligibility treatment of income) form was completed. She said she filled out the PETI form and was waiting for Medicaid to pay for them. She said she did not remember when she filled out the PETI form. She said it took a long time for Medicaid to pay for eyeglasses. SS #3 said Resident #1 had not received his eyeglasses because Medicaid had not paid for them. She said she gave the bill to the business office manager (BOM) after Resident #1 was seen by the eye doctor. The business office manager (BOM) was interviewed on 1/30/25 at 12:51 p.m. The BOM said Medicaid paid for all ancillary services. The BOM said Resident #1 should have received his glasses two weeks after his appointment on 5/16/24. She said if there was a delay in ordering glasses money would be taken out of residents personal needs funds. She said if residents did not have any money then the families would be notified. She said some families were willing to pay out of pocket for glasses. The BOM said the social services department was responsible for making sure residents received their glasses. She said it should not take eight months for residents to receive their eyeglasses. She said Resident #1 should have received his glasses within a month.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on observations, record review and interviews, the facility failed to ensure residents with a feeding tube received appropriate treatment and services for one (#578) of two residents reviewed out of 59 sample residents. Specifically, the facility failed to ensure Resident #578 received his tube feeding administrations as ordered by the physician. Findings include: I. Facility policy and procedure The Enteral Nutrition (feeding tube) policy, revised November 2018, was provided by the nursing home administrator (NHA), on 1/31/25 at 12:41 p.m. It read in pertinent part, Adequate nutritional support through enteral nutrition is provided to residents as ordered. The dietitian, with input from the provider and nurse: estimates calories, protein, nutrient and fluid needs; determines whether the resident's current intake is adequate to meet his or her nutritional needs; recommends special food formulations; and, calculates fluids to be provided (beyond free fluids in formula). Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. If a feeding tube is ordered, the provider and interdisciplinary team document why enteral nutrition is medically necessary. The dietitian monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. II. Resident status Resident #578, age 85, was initially admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), the diagnoses included pneumonia and cerebral palsy (a congenital disorder of movement, muscle tone, or posture). The 11/11/24 minimum data set (MDS) assessment revealed the resident had severely impaired cognition with a brief interview status (BIMS) score of zero out of 15. He required substantial/maximal assistance with toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear and personal hygiene. The MDS assessment documented the resident was receiving 51% or more of his calories through a feeding tube and 501 cubic centimeters (CC) a day of fluid through a feeding tube. III. Observation (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 11:00 a.m. Resident #578 was not in his room and his machine was turned off (see interviews below). IV. Record review The enteral feeding care plan, revised 2/12/24, documented Resident #578 had cerebral palsy, history of impaired swallowing with aspiration pneumonia and nothing by mouth (NPO). Interventions included providing 200 milliliters (ml) water flush via peg-tube as per order, ensuring the insertion site was be free of signs or symptoms of infection, checking the placement of the tube and residual every shift, if residual greater than 500 cubic centimeter (cc) hold feeding and notify the medical doctor, elevating the head of the bed 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding was stopped, having the registered dietitian (RD) evaluate the resident monthly and as needed , monitoring caloric intake, estimating needs and making recommendations for changes to tube feeding as needed. The nutrition care plan, revised 8/15/24, documented Resident #578 was at risk for inability to maintain his nutrition related to diagnosis of dependence on enteral nutrition, gastroesophageal reflux disease (GERD), limited mobility, history of weight loss and underweight. Interventions included providing the enteral feed as ordered: Jevity 1.5 at 70 ml an hour for 22 hours via g-tube, providing 2310 kilocalories, 98 grams protein and 1170 ml water, 250 ml water flush every four hours, flush with 30 ml water before and after tube feeding administration, total water daily 2670 ml, monitoring and recording weight as ordered (weekly) and providing diet as ordered and as resident chooses NPO. The January 2025 CPO documented the following physician's orders for Resident #578: Jevity 1.5 calorie/fiber oral liquid (nutritional supplements) give 70 ml an hour via peg-tube one time a day for enteral nutrition Jevity 1.5 at 70 ml an hour for 22 hours via peg. On at 1:00 a.m. off at 11:00 a.m. Flush with 30 ml water before and after administration. Document total ml formula administered (1540ml). May use Nutren 1.5 if Jevity 1.5 was unavailable and remove per schedule, ordered on 10/1/24. Change bag and tubing every 24 hours at 1:00 a.m. for feeding tube in use, ordered on 12/6/24. 250 ml water flush via g-tube every four hours, ordered on 1/23/25. V. Staff interviews Registered nurse (RN) #2 was interviewed on 1/30/25 at 11:00 a.m. RN #2 said she disconnected Resident #578's feeding at 10:00 a.m. every day and restarted the feedings at 2:00 p.m. RN #2 said Resident #578 was off his tube feeding for four hours daily. -However, the physician's orders indicated to start the feedings at 1:00 p.m. and end the feedings at 11:00 a.m., indicating the resident did not receive feedings for two hours a day, from 11:00 a.m. until 1:00 p.m. RN #2 said the physician's order read Resident #578 was to receive feedings for 22 hours, starting at 1:00 p.m. and ending at 11:00 a.m. RN #2 said Resident #578 went to physical therapy everyday at 10:00 a.m. five days a week. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 said she should have followed the physician's orders. She said she was responsible for taking Resident #578 off the feeding tube early on 1/30/25 (see observations above). She said Resident #578 was taken off at 10:00 a.m. for physical therapy. She said Resident #578 had physical therapy five days a week. She said she needed to follow the physician's orders. The registered dietitian (RD) was interviewed on 1/30/25 at 2:22 p.m. The RD said Resident #578 received enteral feedings for 22 hours a day. She said he did not receive feedings for two hours a day. The RD said she did not get a report on how much volume Resident #578 was receiving. She said she was in constant communication with the nurses about resident's weight and volume. She said Resident #578's weight had been going up and he was getting adequate nutrition The RD said Resident #578 went to therapy five days a week and was off for two hours and he sat at the nurses station. The RD said the tube feeding machine had kept track of information for 24 to 72 hours. She said Resident #578 should be getting the majority of the formula that was prescribed daily within 24 hours. She said Resident #578 should be getting 1540 ml of formula daily. She said the bag that held the formula needed to be changed every 24 to 48 hours. She said when the formula ran out the nurses changed the bag, which was not always at the same time each day. The RD said the physician's order for enteral feedings for Resident #578 read for the feedings to start at 1:00 a.m. and end at 11:00 a.m. The RD said Resident #578 was prescribed 70 ml of formula per hour for 22 hours a day. The RD said Resident #578 should not be off for four hours and the nurse was wrong. The RD said the nurses should have followed the physician's orders. The RD said the nurses could let her know if they needed to make changes to the physician's order. She said the nurses should be communicating with her about making any changes to the orders. She said it would be good to know that Resident #578 was off of his tube feeding for more than two hours so she could adjust the order.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews the facility failed to have a coordinated written plan of care that included both the most recent hospice plan of care and a description of the services furnished by the facility for two (#169 and #12) of three residents out of 59 sample residents. Specifically, the facility failed to ensure Resident #169 and Resident #12 had a written plan of care that included both the most recent hospice plan of care and a description of the services furnished by the facility Findings include: I. Facility policy and procedure A request for the hospice services policy was made on 1/30/25 at 4:15 p.m. to the nursing home administrator (NHA) and was not provided with the other policies requested. The Care Plans, Comprehensive Person-Centered policy, revised March 2022, was provided by the NHA on 1/31/25 at 12:41 p.m. It read in pertinent part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. I. Resident #169 A. Resident status Resident #169, age 69, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included cirrhosis of the liver, a history of stroke and muscle wasting. The 9/27/24 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems per staff assessment and did not participate in the brief interview for mental status (BIMS) assessment. The resident was able to recall the current season and knew she was in a nursing facility. The resident usually understood others and was usually understood in conversations. The assessment indicated the resident was receiving hospice services while a resident of the facility. B. Resident interview (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #169 was interviewed on 1/27/25 at 12:46 p.m. Resident #169 said she recently was admitted to hospice but did not know what the plans were. She said the nurses were telling her one thing and the hospice staff were telling her something else. She asked the hospice nurse to talk to the hospice nurse to provide clarification on her medication orders to the facility nurse. She said the hospice nurse said she would. She said when the facility nurse came in later she said she was unaware of the medication question and said the hospice nurse had not talked to her. Resident #169 said she did not think the communication between the facility and the hospice provider was good and they were yet to hold a care conference to discuss her medical care plan. C. Record review Review of Resident #169's comprehensive care plan, last revised on 1/4/24, revealed documentation that the resident was on hospice services. -The care plan failed to include the explanation of care and services that hospice would provide and that the facility would provide in relation to hospice services and end of life care. The multidisciplinary care conference note, dated 11/13/24, documented a care conference held with the resident, the resident's family and the resident's physician assistant. -The note did not document a discussion with the resident about her declining health or a plan to seek hospice services at the time of the 11/13/24 care conference. The resident's progress notes revealed the resident's primary care physician's assistant (PA) documented an order for the resident to be evaluated for hospice services, dated 11/26/24. The resident was admitted to hospice on 12/13/24. The PA note, dated 12/11//24, documented the resident did have hospice evaluation and was admitted for end stage liver disease. The resident had further decompensation with rapid weight loss. The resident and family were understanding of the clinical situation and in agreement with hospice care. The note documented to coordinate comfort focused treatment plan. Hospice registered nurse services note, dated 1/14/25, read in pertinent part: Problem: Coordination of care needs: hospice. Intervention: Educate facility care providers regarding contacting hospice to ensure continuity of care and allow for continuing case management by the hospice care team. Goal: Continuity of care will be maintained as appropriate to the patient and primary caregiver's needs. D Staff interviews The hospice registered nurse (HRN) was interviewed on 1/30/25 at 2:30 p.m. The HRN said Resident #169 started receiving hospice services on 12/13/24. The HRN said the resident had been forgetful about the details of her hospice services and had been asking several questions about who would be in charge of making her medical decisions and who (hospice or facility staff) would provide her care (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The HRN said she checked in with the facility nurse on Resident #169's unit after each visit and has had lengthy conversations with Resident #169's family. HRN said she set up a care conference meeting with the resident, the facility and the resident's family on 2/5/25. Social services (SS) #1 was interviewed on 1/30/25 at 3:09 p.m. SS #1 said her responsibility was to make hospice referrals per the resident and resident representative preferences. SS #1 said the unit manager was responsible for coordinating care between the facility and the hospice provider. SS #1 said she was under the impression that the floor nurse would develop a resident care plan for hospice services and interventions. The director of nursing (DON) was interviewed on 1/30/25 at 5:10 p.m. The DON said that the hospice provider routinely checked in with the floor nurse to communicate changes in the resident's care. The DON said the floor nurses in return would notify the HRN of any changes in the resident condition and care needs. The NHA was interviewed on 1/30/25 at 5:10 p.m. The NHA said that they would not add hospice care services to the facility care plan because they could not be responsible for another provider's services and could not guarantee that the provider would provide services accordingly. 48114 II. Resident #12 A. Resident status Resident #12, age under 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), the diagnoses included traumatic brain injury, quadriplegia (a condition characterized by the partial or complete loss of motor function, sensation, and autonomic function in all four limbs and the torso) and dementia. The 12/5/24 minimum data set (MDS) assessment revealed the resident had severely impaired cognition with a brief interview status (BIMS) score of zero out of 15. He required substantial/maximal assistance with all activities of daily living (ADLs). The MDS assessment indicated the resident was receiving hospice services. B. Record review The care plan for hospice, initiated 12/5/24 and revised 12/6/24, documented Resident #12 was admitted to hospice for cerebral infarction related to calorie and protein malnutrition. Interventions included offering/providing additional privacy for resident/family whenever possible during dying process, considering room options within community to best meet resident/family needs, working effectively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met and working with nursing staff to provide maximum comfort for the resident. -The care plan failed to include the explanation of care and services that hospice would provide and that the facility would provide in relation to hospice services and end of life care. (continued on next page)

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	065203	A. Building B. Wing	01/30/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The January 2025 CPO documented the following physician orders for Resident #12: Admission to hospice for cerebral infraction related to calorie and protein malnutrition, ordered on 11/27/24. Care conference note for 8/28/24 documented staff will encourage Resident #12 to participate with activities and his work outs with therapy. Staff will encourage resident to participate with his activities of daily living. -Review of the resident's electronic medical record (EMR) did not indicate why a care conference was not held in November 2024 or documentation indicating a care conference was held to discuss the resident admitting to hospice and how the resident's care would be delineated between the hospice staff and the facility staff. C. Staff interviews SS #2 was interviewed on 1/30/25 at 3:08 p.m. SS #2 said care conferences were completed quarterly. SS #2 said she was in charge of making arrangements for when care conferences were held. She said she made arrangements with family members when care conferences were scheduled. SS #2 said Resident #12's care conference should have been held in November 2024. SS #2 said she was not sure why it was not completed. She said a care conference should have been completed. She said the care conference got missed. SS #2 said during the holidays that the families were ok with not having care conference meetings. SS #2 said after the holidays she would resume the care conferences. SS #2 said she had Resident #12 on the calendar for the month of February to hold his care conference meeting. SS #2 said the nursing team would add what services they were providing for the resident. Licensed practical nurse (LPN) #4 was interviewed on 1/30/25 at 3:15 p.m. LPN #4 said SS, charge nurse or MDS coordinator would develop a care plan with goals and interventions. LPN #4 said during care conferences when they implemented or revised the goals and interventions. She said the MDS coordinators entered the goals and interventions for Resident #12. Minimum data set coordinator (MDSC) #1 was interviewed on 1/30/25 at 3:56 p.m. MDSC #1 said she coordinated with the unit managers, charge nurses, hospice company and the provider when implementing and revising goals and interventions. MDSC #1 said she created the goals and interventions for Resident #12. She said she could put in goals and interventions even though a care conference was not held. She said the interventions she entered were individualized. She said hospice sent over a chaplain to meet with Resident #12 and coordinated with the families. The NHA was interviewed on 1/30/25 at 4:00 p.m. The NHA said care conferences were held quarterly. He said he was unaware that the care conference was not held for Resident #12. He was surprised that a progress note was not written. D. Facility follow-up (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 52045 Based on observations, record review and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment for residents and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: -Ensure staff wore the appropriate personal protective equipment (PPE) for Resident #60, who was on enhanced barrier precautions (EBP); and, -Ensure residents were offered the opportunity for hand hygiene prior to meals. Findings include: I. Failed to ensure staff wore the appropriate PPE for Resident #60, who was on EBP A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), retrieved on 1/22/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Observations On 1/27/25 at 10:43 a.m. there was a sign on Resident #60's door which indicated the resident was on EBP. The sign indicated gloves and gowns must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. Resident #60 had an indwelling urinary catheter in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was PPE, including gloves, gowns, eye protection and masks stocked on the back of Resident #60's bathroom door. On 1/27/25 at 11:12 a.m. Certified nurse aide (CNA) #4 and CNA #6 were transferring Resident #60 from bed to a wheelchair using a hoyer lift (mechanical lift). Both CNA #4 and CNA #6 had on gloves but they were not wearing gowns. On 1/30/25 at 9:16 a.m. CNA #7 and CNA #3 were transferring Resident #60 to a wheelchair with the mechanical hoyer lift. CNA #7 and CNA #3 were wearing gloves but they were not wearing a gown. C. Staff interviews CNA #6 was interviewed on 1/27/25 at 11:17 a.m. CNA #6 said staff only needed to wear gloves when providing care for Resident #60, unless they were emptying her foley catheter. CNA #6 said if staff were emptying the resident's foley catheter, then they needed to wear gloves and a gown. Assistant director of nursing (ADON) #1 was interviewed on 1/29/25 at 2:12 p.m. ADON #1 said he was in charge of the facility's infection control program and was certified as an infection preventionist (IP). Licensed practical nurse (LPN) #5 was interviewed on 1/30/25 at 9:14 a.m. LPN #5 said when staff were providing care for Resident # 60, staff were required to put on gloves, gown, mask and face shield. CNA #7 was interviewed on 1/30/25 at 9:18 a.m. CNA #7 said she only needed to put on gloves when providing care for Resident #60. CNA #3 was interviewed on 1/30/25 at 9:19 a.m. CNA #3 said she only needed to put on gloves when providing care for Resident #60 and maybe a mask sometimes. CNA #3 said staff did not get any education training regarding EBP protocols from the nurses. The director of nursing (DON) and ADON #1 were interviewed together on 1/30/25 at 12:35 p.m. ADON #1 said EBP were used for residents with any open wounds, feeding tubes, IV (intravenous) lines and foley catheters. He said staff should wear gowns, mask gloves, and eye wear depending on if they were going to drain foley catheters. -However, the sign on Resident #60's door indicated only gloves and gowns were required to be worn when providing resident care activities (see observations above). ADON #1 said PPE protected staff from spreading infections. The DON and ADON #1 both said in-service's based on individual infection concerns were given to staff along with a paper document for staff to sign that they had been provided with education related to infection control concerns, such as precautions. -Documentation of the facility's infection control in-service educations were requested, however the facility did not provide the documentation by the end of the survey on 1/30/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42838 II. Failed to ensure residents were offered the opportunity for hand hygiene prior to meals A. Professional reference According to the CDC's About Hand Hygiene for Patients in Healthcare Settings Clean Hands, updated 2/27/24, retrieved on 2/4/25 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html, When patients and visitors should clean their hands: -Before preparing or eating food; -Before touching your eyes, nose, or mouth; -Before and after changing wound dressings or bandages; -After using the restroom; -After blowing your nose, coughing, or sneezing; and, -After touching surfaces such as bed rails, bedside tables, remote controls or the phone. Residents in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics and protects healthcare personnel and residents. B. Facility policy and procedure The Hand Hygiene policy, dated 2001, was provided by the director of nursing (DON) on 1/31/25 at 1:29 p.m. It read in pertinent part, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Residents, family members and/or visitors are encouraged to practice hand hygiene. -The facility policy did not identify when to offer residents hand hygiene. C. Observations On 1/27/25 at 11:30 a.m., during the lunch service in the facility's main dining room and the first floor dining room, staff did not offer any of the residents the opportunity to sanitize their hands prior to eating. There were hand sanitizer dispensers mounted on the walls in the dining room, but the mounted hand sanitizer dispensers were not accessible to residents with mobility limitations because they were blocked by dining room tables. On 1/28/25 at 4:11 p.m., during the dinner service in the main dining room, staff did not offer any of the residents the opportunity to sanitize their hands prior to eating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 4:01 p.m., during the dinner service in the main dining room, staff did not offer any of the residents the opportunity to sanitize their hands prior to eating. On 1/30/25 at 9:31 a.m., the dietary manager (DM) was observed attempting to locate hand sanitizer wipes. The DM was unable to locate any hand sanitizer wipes and said the facility must be out of them. She said she would reorder some. On 1/30/25 at 11:07 a.m., during the lunch service in the first floor dining room, staff did not offer any of the residents the opportunity to sanitize their hands prior to eating. D. Resident interviews Resident #131 was interviewed on 1/30/25 at 9:32 a.m. Resident #131 said staff did not offer residents a way to wash or sanitize their hands prior to meals. He said he was one of the few residents who could wash his own hands and he remembered to do it himself. He said not all residents were able to wash their own hands, so they would go without washing their hands before meals. Resident #157 was interviewed on 1/30/25 at 10:50 a.m. Resident #157 said staff did not offer hand hygiene to residents at meals. E. Staff interviews The DM was interviewed on 1/30/25 at 9:31 a.m. The DM said she trained all dietary aides on infection control within the dining room. The DM said the residents were encouraged to use the hand sanitizer that was mounted on the walls but if they preferred the hand sanitizer wipes, the dietary aides could get them one. The DM said it was the residents' choice to clean their hands before meals and they do not force infection control. -However, the mounted hand sanitizer dispensers were not accessible to residents with mobility limitations because they were blocked by dining room tables. -Additionally, staff did not encourage the residents to use the hand sanitizer dispensers on the wall (see observations above). The dietary assistant (DA) was interviewed on 1/30/25 at 10:58 a.m. The DA said staff would ask residents if they wanted hand hygiene at meals and if they wanted it, staff would provide hand sanitizer wipes for residents to sanitize their hands. ADON #1 was interviewed on 1/30/25 at 12.35 p.m. ADON #1 said the facility offered hand sanitizer or sani-wipes at meal time for the residents. ADON #1 said hand sanitizer wipes should be on residents' room trays as well as in the dining room. ADON #1 said all residents should be offered the opportunity to sanitize their hands prior to meals. ADON #1 said the facility usually provided infection control education to staff twice a month verbally and all staff received written education upon hiring. He said the facility conducted random hand washing audits of staff twice a month.