STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065206	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowan Community, Inc	4601 E Asbury Cir Denver, CO 80222

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** 52309 Based on observations, record review and interviews, the facility failed to ensure residents had the right to a dignified existence for two (#51 and #6) of four residents out of 32 sample residents. Specifically, the facility failed to: -Provide Resident #51 with privacy and dignity when receiving care, and, -Respond to Resident #51 and Resident #6's call light timely. Findings include: I. Facility policy and procedure Answering the Call Light policy, revised September 2022, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:50 p.m. It read in pertinent part, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. When answering, knock on the room door, identify yourself and address the resident by his/her name. The Quality of Life-Dignity policy, February 2020, was provided by the NHA on 5/22/25 at 2:51 p.m. The policy 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, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Staff are expected to knock and request permission before entering residents' rooms. Staff speak respectfully to residents at all times. Procedures are explained before they are performed. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedure. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident #51 A. Resident status Resident #51, age 65, was admitted [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Steele-[NAME]-[NAME] syndrome (a rare neurodegenerative disease that affects balance, eye movement, speech and swallowing), progressive supranuclear ophthalmoplegia (inability to move one's eyes at will), limitation of activities due to disability, muscle weakness, repeated falls, cognitive communication deficits, abnormalities of gait and mobility, other frontotemporal neurocognitive disorder (changes in behavior, personality and language) and history of falls. The 2/17/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #51 required extensive assistance with transfers and toilet use. B. Observation On 5/19/25 at 10:10 a.m. Resident #51's door was open. He was in bed with only a t-shirt on. The call light was on the floor behind his headboard. Resident #51 rolled to the edge of the bed to reach the call light. He pushed the call light for assistance to reposition himself. An unidentified certified nurse aide (CNA) responded, without knocking or identifying herself, asked from the doorway what Resident #51 wanted. Resident #51 was difficult to understand (see communication care plan below). The unidentified CNA asked if he wanted water and said she would be back with water. The resident slowly repositioned himself. -The unidentified CNA did not knock, identify herself or get close enough to the resident to hear his request. On 5/22/25 at 9:31 a.m. Resident #51's door was open. He was standing with his back to the door. CNA #2 walked in without knocking or identifying herself. C. Resident interview Resident #51 was interviewed on 5/19/25 at 10:10 a.m. Resident #51 said he felt he was not treated with respect and dignity by the staff. He said during care the staff spoke to him in an aggressive voice and did not always wait for a response. He said he felt that the staff lacked compassion. The resident said he liked his privacy and the staff often left the door open when providing personal care for him which made him feel uncomfortable. He said that many times staff just walked in without knocking. -The call light log revealed the call light was not answered for one hour and twenty six minutes on 5/14/25 at 11:33 a.m. D. Resident representatives interview (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51's representative was interviewed 5/21/25 at 10:51 a.m. The resident's representative said that they started to have concerns with Resident #51's care and the resident had requested a camera. She installed a camera in plain sight and posted a sign stating a camera was in use. She said the camera was pointed at the bed and door and was motion activated. The resident's representative said she had witnessed the resident's door being left open on several occasions when he was not wearing clothes and during care. She said she witnessed staff not being patient with the resident. Resident #51's representative said the resident had to wait for long periods of time until his call light was answered. She said on 5/14/25 she entered Resident #51's room before lunch, the door had been left open, the resident was not wearing any clothes, the room was freezing and the sheets were stained with urine. She said she pushed the call light and waited an hour and half before anyone responded. Resident #51's representative said during that time she walked to the nurses'station and requested assistance. E. Record review Resident #51's activities of daily living (ADL) care plan, dated 9/7/23 revised on 5/14/25, revealed the resident had an ADL self-care performance deficit related to progressive supranuclear ophthalmoplegia and impaired balance and mobility. Pertinent interventions included providing Resident #51 with assistance with dressing and toileting The communication care plan, dated 10/4/23 revised 5/14/25, indicated Resident #51 had a hearing deficit, stuttered and slurred his words, was slow to respond, and had difficulty with word finding. Pertinent interventions included allowing the resident adequate time to respond, do not rush the resident, requesting clarification to ensure understanding, facing the resident when speaking, asking yes/no questions, using simple, brief and consistent words and cues, using alternative communication tools as needed, speaking to the resident on an adult level, speaking clearly and slower than normal and validating the message by repeating aloud. The facility's call light system data for Resident #51 was provided by the NHA on 5/21/25 at 12:24 p.m. The log from 5/1/25 to 5/21/25 revealed the following: Staff response time to Resident #51's call light was greater than 20 minutes 18 times out of 66 calls or 39.3%. Staff response time to Resident #51's call light was greater than 60 minutes 18 times out of 66 calls or 39. 3%. E. Staff interviews CNA #2 was interviewed on 5/22/25 at 9:25 a.m. CNA #2 said when she was providing care to a resident, she pulled the curtain and closed the door for privacy. She said she talked to residents during care and if a resident did not respond to the care she would leave, after the resident was safe, and returned with a different approach within a few minutes. CNA #2 said Resident #51 was not combative or resistant to care, but preferred to do things his way. She said that it was important to answer call lights as soon as possible. (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 5/22/25 at 11:15 a.m. CNA #1 said when she was providing care she closed the door and pulled the curtain for privacy. She said she talked to residents while she provided care and if a resident was combative or resistant to care she said she explained the care that was needed in a calm voice, but that she did not force a resident to accept care. CNA #1 said Resident #51 was not combative or resistant to care and if staff explained what needed to be done, he worked with staff. CNA #1 said she tried to answer call lights as soon as possible but sometimes it was difficult if she was helping another resident. She said she tried to get to a room at least within 10 minutes. The director of nursing (DON) was interviewed 5/22/25 at 2:30 p.m. The DON said she expected call lights to be answered within 10 minutes, but sometimes that was difficult depending on what was happening with other residents or if it was during a meal. She said everyone was responsible for answering the call lights. She said residents who were at a high risk for falls should be a priority when answering call lights. The DON said she expected that residents were treated with respect and dignity. She said the staff were provided education on these topics. She said she investigated immediately if there was a concern about respect and dignity. The DON was interviewed on 5/22/25 at 4:07 p.m. The DON said the call light system was an electronic banner that hung on the two units. She said that there was one computer, located at the west nurses'station, that had the room number and the wait time posted. She said she would get an alert, by email from the system, if a call light had been on longer than 30 minutes. The DON said if she was in the building she went to the nurses' unit to investigate why there was a long call light response. She said if she was not in the building, she waited until the next business morning to investigate the long response time. The DON said she used to review call light response time daily but has not done that lately. 48112 III. Resident #6 A. Resident status Resident #6, age [AGE] years, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included multiple sclerosis (chronic progressive disease of the central nervous system), depression, peripheral vascular disease (blood circulation to the body's tissue is restricted due to blocked blood vessels), contracture of muscle in multiple sites, psychotic disturbance, mood disturbance and left elbow contracture. The 2/18/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for toileting, showering, dressing and personal hygiene. The assessment revealed she had an impairment to one upper extremity and an impairment to both lower extremities. B. Resident interview and observation (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was interviewed on 5/20/25 at 11:02 a.m. The call light was clipped on the left side of her shirt. She said she used the call when she needed toileting assistance. She said sometimes it felt pointless to use the call light because the staff did not come for a long time. The resident said she kept her window open because sometimes she was left soiled and she did not want her room to smell bad. C. Resident representative interview Resident #6's representative was interviewed on 5/20/25 at 10:40 a.m. She said the resident's call light was frequently left unanswered for a long time period. She said when the resident had to wait a long time for staff to respond to her call light the resident called the representative. The representative said she called the facility to check on the resident. The resident's representative said the resident told her she felt he said felt helpless. D. Observation Resident #6 resided on the west unit. On 5/22/25 at 1:20 p.m. an electric banner hung on the wall in the east unit that was used to display the activated call lights. On 5/22/25 at 1:28 p.m. an electric banner hung on the wall in the west unit, and a tablet was observed in the west unit nurse's station. E. Record review The facility's call light system data for Resident #6, from 3/1/25 to 5/21/25, was provided by the NHA on 5/22/25 at 11:04 a.m. The call light data revealed the following: Staff response time to Resident #6's call light was greater than 30 minutes 57 times out of 233 calls, or 24. 4% of the time. The call light response time ranged from 30 minutes to 266 minutes. F. Staff interviews CNA #4 was interviewed on 5/22/25 at 1:20 p.m. She said she should answer call lights as quickly as possible, typically within 30 seconds to one minute. She said it was important to respond to call lights quickly because she never knew what the resident needed. She said it was important to make the resident feel heard, seen and to acknowledge their needs. She said it was hardest to answer call lights when she was helping another resident shower, when she was assisting residents with meals in the dining room and when she was in another resident's room. She said the only way she could see if a resident's call light was on was by looking at the electric banner that hung on the wall in each unit. She said she was not provided direction on what to do when it was hard to answer the call lights. She said the nurses or other staff did not help answer call lights. She said the residents were frustrated when they needed to wait a long time for someone to respond to their call light. She said, she did not know if Resident #6 was frustrated waiting a long time for staff to respond to her call light. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 5/22/25 at 1:28 p.m. She said she should answer call lights as soon as possible. She said the nurses and the CNAs were responsible for answering the call lights. She said it was important to answer call lights because the resident could have an emergency. She said it was hardest to answer the call lights right before breakfast because everyone liked to eat breakfast in the dining room and wanted their showers before they had breakfast. She said it was not hard to answer the call lights in a timely manner if the staff knew the resident's daily routine. She said the residents became frustrated if they had to wait a long time. She said one resident had their family call the facility if the resident had to wait a long time. She said there were two ways to see if a resident's call light was on. She said one way was the electric banner above the hallway in each unit and the other way was a computer tablet that was in the nurse's station. She said Resident #6 sometimes was frustrated when she had to wait for someone to respond to her call light. The DON was interviewed on 5/22/25 at 3:59 p.m. She said everyone in the building was responsible for responding to call lights. She said staff should respond to call lights within 10 to 15 minutes. The DON said meal time was a time of day that was hard to respond to call lights in a timely manner. She said she heard of residents' complaints about call lights in the past and she said it was due to agency staff. The DON said she reviewed the call light records. She said she was not aware Resident #6 was frustrated with the call light response time. The DON said she received an email for any call light that was on for more than 30 minutes. She said she identified that residents waited the longest during meal time, during change of shift in the morning and after dinner. The DON said she did not have an immediate plan to reduce the call lights.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48112 Based on interviews and record review, the facility failed to maintain a system of documenting grievances and demonstrating prompt actions for one (#6) of two residents out of 32 sample residents. Specifically, the facility failed to effectively address, resolve and demonstrate the facility's response to individual grievances for Resident #6. Findings include: I. Facility policy and procedure The Grievance policy and procedure, revised 5/8/23, was provided by the regional director of clinical services (RDCS) on 5/22/25 at 5:44 p.m. It read in pertinent part, The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten working days of the filing of the grievance or complaint. II. Resident #6's representative interview Resident #6's representative was interviewed on 5/20/25 at 10:40 a.m. She said she had filed several grievances since the beginning of May 2025 with the facility. She said the facility had not told her the resolution. She said she was frustrated with one of the grievances because it had to do with how one of the staff members communicated with the resident. She said Resident #6 told her it did not make her feel well when the staff member cared for her. The resident's representative said the other grievance that was important to her to resolve was about the resident's head support. She said it was important for the staff to position the resident correctly due to the resident's comorbidities. The resident's representative said she did not know who at the facility was responsible for resolving grievances. III. Observation On 5/22/25 at 12:35 p.m. Resident #6 in her room leaning to her right side in her wheelchair. The director of nursing (DON) asked certified nurse aide (CNA) #2 to help readjust the resident. IV. Record review Two grievance forms completed by Resident #6's representative were provided by the nursing home administrator (NHA) on 5/20/25 at 4:30 p.m. The first section of the form revealed who the complaint or concern report was received from, the name of the resident, the name of the person reporting the concern, the relationship to the resident, the date and time of of the report, and the nature of the concern and a line for employee signature and a date line. The second section was the response given or action taken at the time of the report. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The first grievance form, dated 5/8/25, revealed the family/legal representative completed the form. It revealed the nature of the concern was the new CNA did not speak English, so the resident could not communicate with her. The form documented the representative requested the CNA to use a translation system so the two of them could communicate. -The rest of the form was left blank. There was no documentation showing what steps were made to reach out to the resident's representative and to resolve the grievance. The second grievance form, dated 5/10/25 at 12:44 p.m., revealed the family/legal representative completed the form. It revealed the nature of concern was the resident's head support was not fastened to the right side of the wheelchair and she was positioned poorly, causing her to be slouched to the right side all day. The form documented the representative visited the facility at 2:30 p.m. and used the headrest to straighten the resident into a more upright position. The form documented the resident spent most of her day poorly positioned and the headrest should be used on her chair properly. -However, the rest of the form was left blank. There was no documentation showing what steps were made to reach out to the resident's representative and to resolve the grievance. V. Staff interviews The DON was interviewed on 5/22/25 at 3:46 p.m. The DON said Resident #6 had a small pillow that attached to the wheelchair for head support. She said this was not apart of the resident's care plan and was not on the Kardex (an abbreviated care plan), but it needed to be. She said the nursing staff was not trained on how to position the resident's head after Resident #6 filled the grievance on 5/10/25. The NHA was interviewed on 5/22/25 at 4:51 p.m. The NHA said anyone could fill out a grievance form, including the residents and their representatives. She said the staff could help a resident or a resident's representative complete a grievance form. She said the social services director (SSD) was the grievances coordinator, but the SSD was new so the NHA and the DON were helping review grievances. The NHA said she reviewed grievances in the morning meeting with the department managers. The NHA said during the morning meeting she determined who was responsible for following up on the grievance. The NHA said the department manager talked to the resident or the resident's representative, completed the appropriate steps, found an appropriate resolution and asked the resident or the resident's representative if the resolution satisfied their concern. The NHA said depending on the grievance, the department manager had 72 hours to resolve the complaint. The NHA said if the grievance required training, it might take longer than 72 hours for a resolution. The NHA said she was aware of the two two grievances submitted by Resident #6's representative and she would find out why the grievance form was not completed in its entirety. VI. Facility follow-up The facility provided an updated copy of the two grievance forms (5/8/25 and 5/10/25) grievance on 5/23/25 at 2:25 p.m. It revealed both forms were signed on 5/22/25 (during the survey) by facility staff and there was a handwritten line that said agrees to grievance resolved resident with the resident's signature and date. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the grievance forms were submitted by the resident's representative, not the resident. There was no documentation indicating the resident's representative was notified or approved the resolutions on the grievance forms she submitted in May 2025.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure one (#6) of three residents out of 32 sample residents with limited range of motion received appropriate treatment and services. Specifically, the facility failed to ensure preventative measures were put into place for Resident #6's right foot. Findings include: I. Facility policy and procedure The Restorative Nursing Services policy and procedure, revised July 2017, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:52 p.m. It read in pertinent part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence and self-esteem; and participating in the development and implementation of his/her plan of care. II. Resident #6 A. Resident status Resident #6, age [AGE] years, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (chronic progressive disease of the central nervous system), depression, peripheral vascular disease (blood circulation to the body's tissue is restricted due to blocked blood vessels), contracture of muscle in multiple sites, psychotic disturbance, mood disturbance and left elbow contracture. The 2/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) assessment score of 15 out of 15. She was dependent on staff for toileting, showering, dressing and personal hygiene. The assessment revealed she had an impairment to one upper extremity and an impairment to both lower extremities. The assessment revealed she received a restorative nursing programs, including passive range of motion and splint or brace assistance five days a week. B. Resident interview and observation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was interviewed on 5/20/25 at 11:02 a.m. The resident was in her wheelchair in her room with socks on her feet. There were two soft heel boots on a chair next to the resident's bed. She said she did not wear boots on her feet because the staff did not know how to put them on correctly. She said two staff members put them on correctly, but when the other staff put them on it caused her pain. C. Observations On 5/21/25 at 12:49 p.m. the resident was in her room. She was in her wheelchair with socks on her feet. There were two soft heel boots observed on a chair next to the resident's bed. On 5/22/25 at 12:41 p.m. the resident was in her room. The director of nursing (DON) offered to place the right boot on the resident's foot. The resident declined. The DON offered to place a pillow under both feet and the resident accepted. The resident said she was comfortable. D. Record review The restorative nursing care plan, initiated on 11/6/24, revealed the resident had the potential to benefit from participation in restorative nursing related to limited range of motion and to maintain current function. Interventions included monitoring the resident's tolerance to the restorative program, providing occupational therapy and physical therapy as needed for evaluation and treatment and reviewing progress toward goals and participation on a monthly basis -The care plan did not include documentation indicating the use of the foot drop boot for the right lower extremity. Review of Resident #6's May 2025 CPO revealed the following physician's order: Foot drop boot to the right lower extremity for contracture management and range of motion per physical therapy, ordered 6/1/24. -Review of the December 2024, January 2025, February 2025, March 2025, April 2025 and May 2025 (5/1/25 to 5/22/25) medication administration record (MAR) and treatment administration record (TAR) did not reveal documentation that the the foot drop boot was administered according to the physician's orders. -Review of the resident's electronic medical record (EMR) revealed there was no documentation that the foot drop boot was administered or refused according to the physician's orders. III. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 5/22/25 at 10:00 a.m. She said there was a restorative certified nurse aide (certified nurse aide) who trained the nurses and the CNAs on restorative nursing services. She said about half of the nursing staff were trained to provide restorative nursing services to residents. She said she knew what the resident's restorative program was based on the resident's care plan and the physician's orders. She said the restorative CNA knew what care to provide based on the Kardex (an abbreviated care plan) and the EMR. She said Resident #6 had a physician's order for a foot drop boot but she did not know why it was not showing up on the MAR or TAR for the staff to administer. She said she looked closer and the order was not scheduled. She said if it was not scheduled, then the order would not show up on the MAR and TAR. She said restorative services were important to provide to residents because it prevented further contractures and it helped the resident continue their independence and mobility. The DON and the regional director of clinical services (RDCS) were interviewed together on 5/22/25 at 12:17 p.m. The DON said the restorative CNA trained the staff to complete the restorative nursing services. The DON said the restorative CNA and another CNA provided restorative nursing services. She said the CNA mostly provided functional maintenance services like placing and removing splints and braces. She said the therapy department made restorative nursing recommendations and trained the CNAs. The RDCS said the nurses knew what restorative services a resident received based on the physician's orders. She said the restorative CNA and the CNAs knew restorative services based on POC. The RDCS said the care plan triggered the Kardex that was transferred to the POC. The DON said Resident #6's restorative nursing services were passive range of motion, left splint for her upper extremity and transfer wheelchair sit-ups. The DON said the foot drop boot was a passive ankle stretch and the nursing staff were responsible for providing the boot to the resident. The DON said she did not know Resident #6 had two boots in the resident's room and went to the resident's room to look at them after the interview (see observations above). The DON and the RDCS were interviewed together again on 5/22/25 at 3:36 p.m. The DON said since the physician's order for the foot drop boot did not have a frequency, the foot drop boot was not administered per the physician's order because it did not show up on the nurse's daily MAR and TAR. The DON said if the resident refused the foot drop boot in the future, an alternative could be offering a pillow if the physician and the rest of the interdisciplinary team agreed to the intervention.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure one (#18) of three residents out of 32 sample residents received dental services timely. Specifically, the facility failed to arrange a referral for a dental surgical appointment to remove the permanent implants on Resident #18's lower gums so she could be fitted with new lower dentures. Findings include: I. Facility policy and procedure The Dental Services policy and procedure, revised December 2016, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:29 p.m. It read in pertinent part, Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures. II. Resident #18 A. Resident status Resident #18, age 78, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included depression, vascular dementia and hypertension. The 4/1/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required supervision with toileting, personal hygiene, bed mobility, transfers and required set-up assistance with eating. The assessment did not indicate if the resident had dentures, loose fitting dentures or had difficulty with chewing. B. Resident interview and observation Resident #18 was interviewed on 5/19/25 at 1:50 p.m. Resident #18 said her lower dentures did not fit correctly and were snap-in dentures. She said she needed fixative for her upper dentures because they would not stay in place. She said she had been seen by the dentist but her insurance would not cover the cost to get the dental implant screws removed from her lower jaw so that she could be fitted with new dentures. She said not having lower dentures made it more difficult to chew. Resident #18 was sitting in her wheelchair in her room. Two screws were permanently implanted into her lower gums. The resident had lower dentures in her mouth. Resident #18's upper dentures were loose and the resident had to continuously adjust them back onto her upper jaw. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18 was interviewed a second time on 5/21/25 at 10:00 a.m. Resident #18 said the facility gave her some fixative for her upper dentures so they would not keep coming loose. C. Record review The dental/oral health care plan, initiated 6/24/21, documented Resident #18 was edentulous (did not have any natural teeth). Interventions included coordinating arrangements for dental care, transportation as needed (initiated 6/24/21), providing diet as ordered and consulting with the dietitian (initiated 6/24/21), offering mighty shakes (initiated 8/8/24), observing and reporting any signs of oral or dental problems needing attention (initiated 6/24/21) and the resident was refused a mechanically altered diet (initiated 8/8/24). -A comprehensive review of the care plan failed to reveal any follow up for the resident's lower dentures or a plan to replace her snap-in dentures. The 3/5/25 dental provider progress note documented Resident #18's upper and lower dentures were made [AGE] years ago and the resident no longer wore the lower denture. The note documented Resident #18 had significant bone loss and the dental implants were sticking out of her gum tissue. The resident complained the dental implants hurt her and she wanted them removed and new dentures made. The note indicated the plan was to refer Resident #18 to a specialty dental clinic to have the dental implants removed. -A comprehensive review of Resident #18's electronic medical record (EMR) failed to reveal documentation of communication with the specialty dental clinic to have the dental implants removed. -The resident's EMR failed to reveal communication to Resident #18's representative to coordinate a plan of care for Resident #18's dentures. III. Staff interviews The licensed clinical social work mentor was interviewed on 5/20/25 at 12:15 p.m. The licensed clinical social work mentor said the facility did not currently have a social work director and had recently hired a social work assistant. She said Resident #18 did not like her dentures. She said after she reviewed Resident #18's EMR she said Resident #18 had been seen by a dentist and had been referred to a specialty dental clinic to remove the lower gum implants for the old dentures so she could be refitted for new ones. She said she would follow up to see if an appointment was made. The social services assistant (SSA) was interviewed on 5/21/25 9:30 a.m. The SSA said she had called the dentist on 5/20/25 to verify Resident #18's referral to the dental specialty clinic and had a phone call out to the dental specialty clinic on 5/21/25 to make an appointment for the procedure. The licensed clinical social work mentor was interviewed again on 5/22/25 at 2:15 p.m. The licensed clinical social work mentor said when there was a referral there should be documentation of the communication between the provider and the facility. She said the SSA made a call on 5/21/25 to the specialty dental clinic regarding getting Resident #18's implants removed. She said she would follow up with the SSA and find out if the clinic had called back with an appointment time.

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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** 48112 Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services for two (#48 and #38) of four residents reviewed for hospice care services out of 32 sample residents. Specifically, the facility failed to: -Establish a communication process, including how the communication would be documented between the facility and the hospice provider for Resident #48 and Resident #38; and, -Ensure hospice agency staff notes were easily accessible to the facility staff and have consistent documentation of hospice care visits in Resident #48 and Resident #38. Findings include: I. Facility policy and procedure The Hospice Care policy and procedure, revised 2/29/24 was provided by the nursing home administrator (NHA) on 5/22/25 at 2:52 p.m. It read in pertinent part, When a facility resident elects to have hospice care, the facility staff communicates with the hospice agency to establish and agree upon a coordinated plan of care that is based upon an assessment of the resident's need and living situation in the facility. Hospice communication will be reviewed and added to the medical record. II. Resident #48 A. Resident status Resident #48, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Huntington's disease (a neurodegenerative disorder affecting movement, thinking and emotional control), drug induced parkinsonism (neurological syndrome causing slow movements, tremors and rigidity) and type 2 diabetes mellitus. The 4/9/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. The assessment revealed the resident received hospice services. B. Resident's representative interview (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative was interviewed on 5/19/24 at 2:04 p.m. She said she was frustrated with the communication between the facility staff and the hospice staff. She said it was important for the resident's Broda chair (specialized wheelchair) to be replaced. She said the chair was broken for the past three weeks. She said the durable medical equipment company sent a chair last week but the facility said they could not locate the chair. The resident's representative said it was important to replace the chair to make sure the resident was comfortable. She said she visited the resident often but she wanted to visit the resident and not constantly check with the facility to see if things were being done like the chair being replaced. C. Observations On 5/19/25, between 11:30 a.m. and 12:25 p.m. hospice registered nurse (HRN) #1 was observed talking to Resident #48's representative and other residents and staff in the dining room. -However, the facility did not have documentation of HRN #1's visit with the resident (see record review below). D. Record review The hospice care plan, revised 8/27/24, revealed the resident received additional support services through hospice secondary to advanced Huntington's. Interventions included a hospice nurse visiting one to two times per week, a hospice certified nurse aide (CNA) visiting twice weekly to assist with showering and bathing, grooming and hygiene, hospice staff participating in care, referring to the hospice care plan and collaborating with hospice staff regarding resident care. The skin integrity care plan, revised 8/2/24, revealed the resident had potential for skin integrity problems due to choreatic movements (irregular movements), impaired mobility, incontinence and fall risk. Interventions included hospice providing a new wheelchair, initiated 5/9/25. Review of Resident #48's May 2025 CPO revealed the following physician's order: Admit to hospice with Huntington's disease, ordered 10/15/24. -However, a review of Resident #48's electronic medical record (EMR) revealed no documentation of visits from the hospice provider from 4/2/25 to 5/22/25. The 5/9/25 interdisciplinary (IDT) note revealed the resident bumped her head on her chair. The new interventions put in place was hospice to provide a new wheelchair. -However, there was no further documentation that a new chair was delivered by hospice. III. Resident #38 A. Resident status Resident #38, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included chronic atrial fibrillation, chronic embolism and thrombosis, dementia, psychotic disturbance, mood disturbance and anxiety. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/28/25 MDS assessment revealed the resident was cognitively impaired with a BIMS score of four out 15. The assessment revealed the resident received hospice services. B. Record review The hospice care plan, initiated 11/24/23 and revised 5/22/25 (during the survey), revealed the resident received additional support through hospice secondary to advanced Huntington's disease. Interventions included a hospice nurse visiting one to two times per week, a hospice CNA visiting twice weekly to assist with showering and bathing, grooming and hygiene, hospice participating in care, referring to the hospice care plan and collaborating with hospice staff regarding resident care. Review of Resident #38's May 2025 CPO revealed the following physician's order: admitted to hospice with Huntington's disease, ordered 10/15/24. -A review of Resident #38's eEMR revealed no documentation of visits from the hospice provider from 4/11/25 to 5/22/25. IV. Staff interviews Registered nurse (RN) #1 was interviewed on 5/22/25 at 9:46 a.m. She said she knew a resident was on hospice services through the end of the shift report and in the resident's medical record under special instructions. She said sometimes the hospice staff checked in when they visited the resident and sometimes they did not check in with her. She said it depended on the type of visit. She said the hospice staff did not document on paper when they visited the residents. RN #1 said the designated hospice coordinator was the social services director (SSD), but the SSD was new so the director of nursing (DON) helped. RN #1 said h Resident #48 was on hospice services. She said she did not work 5/19/25 and she was not told the hospice nurse made a visit on 5/19/25. She said she did not have a way to check if the hospice nurse made a visit. She said hospice was responsible for all of the durable medical equipment Resident #48 needed. She said when a new piece of medical equipment was needed, the unit nurse told the hospice nurse and the hospice nurse facilitated the resident's need. She said the Broda chair had been broken for a long time. She said the hospice staff had taken a long time to replace the chair. She said the Broda chair was important for Resident #48 because it kept her comfortable with her Huntington's disease. RN #1 said h Resident #38 was on hospice services. She said the hospice nurse visited twice a week. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HRN #1 was interviewed on 5/22/25 at 11:10 a.m. She said when she visited residents who were receiving hospice care, she tried to check in with the unit nurse first, if they were busy, she tried to see if the assistant director of nursing (ADON) or the DON. She said there was a binder for each resident in the DON's office. She said the DON's office was often locked so she was unable to sign in the binder. She said she should leave a progress note but she was not consistent. She said she always gave a verbal report to the unit nurse after she saw her hospice residents. She said the hospice office was responsible for sending hospice visit notes, the hospice's plan of care, hospice certification and hospice orders by fax. She said Resident #48 and Resident #38 were her hospice residents. She said she would ask the hospice agency to send any notes to the facility going forward. HRN #1 said she visited Resident #48 on 5/19/25 around lunchtime. HRN #1 said the hospice agency was responsible for the resident's medical equipment. She said she was aware of the issues with Resident #48's Broda chair. She said it had been a nightmare the past couple of weeks trying to find out what happened with replacing her chair. She said the Broda chair had been broken for a couple of weeks. She said the hospice agency first sent one Broda chair but the facility refused it because it was too small. She said the durable medical equipment company did not coordinate with the facility when they delivered the chair. She said she talked to the durable medical equipment company and the hospice agency. She said the durable medical equipment company changed their delivery process. She said the company now required a signature when they delivered medical equipment. She said a signature would be helpful because it would track down who signed for the DME. She said it was important for Resident #48 to have a working Broda chair because she did not like to be in her room. She said Resident #48 liked going to the dining room and going outside. The DON and the regional director of clinical services (RDCS) were interviewed on 5/22/25 at 12:03 p.m. The DON said the staff knew if a resident was on hospice services based on the physician's orders and during shift reports. The RDCS said under the payor and special instructions section of the resident's EMR it specified if the resident was on hospice services. The DON said the hospice staff checked in and out with the unit nurse when they visited a resident. The DON said the care plan said how often hospice staff visited. She said the SSD was the hospice coordinator but she was new so the DON was helping. The DON said the hospice staff documented their visit in their own EMR system and sent their notes every two weeks. She said the nurses should be able to look at the hospice notes in the resident's EMRs. The DON said Resident #48 and Resident #38 received hospice services. She said the hospice agency was responsible for the resident's medical equipment. She said she knew the medical equipment company delivered one Broda chair, but it was too small. She said she was not aware Resident #48 was still waiting for a replacement. The RDCS said it was important to have a communication process documented to ensure the resident's needs were addressed and met 24 hours per day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of two units. Specifically, the facility failed to: -Ensure housekeeping staff followed the proper cleaning techniques for cleaning resident rooms and disinfecting high frequency touched areas; -Ensure housekeeping staff were trained appropriately on housekeeping procedures; -Ensure housekeeping staff changed cleaning rags between different sides in a double occupancy resident room; -Ensure housekeeping staff followed the appropriate procedure when cleaning resident bathrooms; and, -Ensure housekeeping staff performed appropriate hand hygiene with glove changes. Findings include: I. Professional reference According to Assadian O, Harbarth S, Vos M, et al. Practical recommendations for routine cleaning and disinfection procedures in healthcare institutions: a narrative review. The Journal of Hospital Infection. (2021 Jul);113:104-114 was retrieved on 5/26/25 from https://pubmed.ncbi.nlm.nih.gov/33744383/, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 5/26/25 from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Common high-touch surfaces include: -bedrails; -IV (intravenous) poles; -sink handles; -bedside tables; -counters; -edges of privacy curtains; -patient monitoring equipment (keyboards, control panels); -call bells; and, -door knobs. According to the CDC ' s Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 5/26/25 from https://www.cdc.gov/handhygiene/providers/index.html, Cleaning your hands reduces the spread of potentially deadly germs to patients. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. II. Facility policy and procedure The Cleaning and Disinfecting Resident Rooms policy and procedure, revised August 2013, was provided by the nursing home administrator (NHA) on 5/22/25 at 3:08 p.m. It read in pertinent part, Clean all high-touch personal use items (lights, phones, call bells, bedrails) with disinfectant solution. Perform hand hygiene after removing gloves. III. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 5/22/25, beginning at 9:38 a.m. and ending at 10:35 a.m., housekeeper (HK) #1 was observed exiting room [ROOM NUMBER] and removing her gloves. She pushed the cleaning cart to room [ROOM NUMBER]. She entered room [ROOM NUMBER] and washed her hands in the bathroom. She returned to the cleaning cart and put gloves on. HK #1 removed a cleaning tray from the cart which contained disinfectants and a toilet brush. She placed the cleaning tray on the bathroom floor in room [ROOM NUMBER]. She sprayed the sink, the toilet, and poured cleaner into the toilet bowl. She emptied the trash in the bathroom and the bedroom. After two minutes, HK #1 returned to the bathroom and scrubbed the inside of the toilet with the toilet brush, flushed the toilet and placed the toilet brush back in the holder on the cleaning tray. She sprayed the toilet rim and under the seat. She removed a yellow rag and washed the inside of the sink, around the sink, the base of the sink and the hand rails. She wiped the alcohol based hand sanitizer dispenser and the paper towel dispenser. HK #1 proceeded to use a black rag to wipe the rim of the toilet, the bottom of the seat, the top of the seat, the toilet lid, the toilet tank and the top of the toilet tank. She used a second black rag to repeat the process. She returned the cleaning tray to the cart and disposed of the soiled rags in a trash bag hanging on the side of the cart. She removed her gloves and entered the bathroom to wash her hands. -HK#1 failed to disinfect the toilet from top to bottom and clean to dirty. HK#1 put on clean gloves and sprayed the door handles in the room and both residents ' overbed tables and night stands. She used a yellow rag to wipe down the top of bed A's overbed table, the base of the overbed table and then the top again. Using the same yellow rag, HK #1 moved to bed B and wiped that resident ' s night stand top and front, then moved to bed A's night stand and repeated the process a second time with the same rag. HK #1 placed the soiled rag back into the bag for soiled rags, removed a clean yellow rag from the cart and wiped the door knobs of the bedroom and bathroom doors. She removed linens from behind the door and placed them in a plastic bag and into the laundry cart. She removed her gloves and put on clean gloves, without performing hand hygiene. She placed multiple trash bags into the two trash cans. She removed the dust mop from the cart and swept the room. She swept under the night stands and beds. She swept the debris to the entrance and used a broom and dust pan to pick up the debris. She placed the broom and dust pan back onto the cart. HK #1 then mopped the room, removed the mop pad and discarded it and placed the mop handle on the cart. She removed her gloves and pushed the cart to room [ROOM NUMBER] without performing hand hygiene. -HK #1 failed to disinfect high touch areas such as the bed remotes, the call lights and the light switches. -HK #1 failed to use a separate clean rag to clean bed B's side of the room after cleaning Bed A ' s side of the to prevent cross contamination. -HK #1 failed to perform hand hygiene after removing her gloves and putting on new glove and after exiting the residents ' room. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews HK #1 was interviewed on 5/22/25 at 10:35 a.m. HK #1 said she washed her hands when she finished cleaning the bathroom and when the room was finished being cleaned. She said she did not know she needed to wash her hands every time she removed her gloves and put on clean ones. She said the high touch areas that she needed to clean were the door knobs, overbed table and the night stands. She said when she cleaned the toilet, she cleaned it from bottom to top. The housekeeping supervisor (HKS) was interviewed on 5/22/25 at 10:41 a.m. The HKS said HK #1 should have performed hand hygiene after cleaning the bathroom, with any gloves changes and when exiting the room. He said high touch areas included door knobs, call lights, light switches, bedside tables, night stands and bed remotes, which should be disinfected daily. He said HK #1 should have used a separate clean rag for each side of the room in a double occupancy room to prevent the spread of germs. He said the toilet should always be cleaned from top to bottom or clean to dirty. He said he would immediately retrain housekeeping staff on the correct process for cleaning resident rooms. The infection preventionist (IP) was interviewed on 5/22/25 at 3:37 p.m. The IP said the toilet should always be cleaned from top to bottom and a separate cleaning cloth should be used for each side of the residents ' room. She said high touch areas included door knobs, call lights, light switches, bedside tables, night stands and bed remotes, which should be disinfected daily. The IP said hand hygiene should be performed with any glove changes. The director of nursing (DON) was interviewed on 5/22/25 at 4:23 p.m. The DON said toilets should be cleaned from clean to dirty, starting at the top of the toilet. She said hand hygiene should be performed with any glove changes and a different rag should be used to clean each side of the room. She said high touch areas included door knobs, call lights, light switches, bedside tables, night stands and bed remotes, which should be disinfected daily. The DON said it was important for the HKs to follow the correct cleaning procedure to prevent the spread of infection. E. Facility follow up: The HKS provided the inservice, dated 5/22/25, of retraining the house keeping staff on the process of cleaning and disinfecting resident rooms.