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** 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 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. (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	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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. II. Resident #51 A. Resident status (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, age [AGE], 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 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. (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 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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of 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.

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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. 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews the facility failed to ensure one (#51) of five residents were free from abuse out of 32 sample residents. Specifically, the facility failed to protect Resident #51 from verbal and physical abuse from two staff members. Findings include: I. Facility policy and procedure The Abuse policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 5/19/25 at 10:38 a.m. It read in pertinent part, Residents have the right to be free from abuse. This includes verbal, mental or physical abuse. Providing a safe environment for the resident is one of the most basic and essential duties of our facility. Employees have a unique position of trust with the vulnerable residents. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff or other agencies serving the residents. II. Resident #51 A. Resident status Resident #51, age [AGE], 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. 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 staff lacked compassion. He said during care the staff handled him roughly by shaking and pulling him. C. Resident #51's representatives interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51's representative was interviewed on 5/21/25 at 10:51 a.m. Resident #51's representative said she started to have concerns with Resident #51's care and the resident had requested a camera in his room. She said she installed a camera in the resident's room 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. She said she witnessed staff not being patient with the resident, pulling on his arms and using an aggressive tone when speaking with the resident. Resident #51's family member said on 5/13/25 two certified nurse aides (CNA), CNA #5 and CNA #6, were abusive towards the resident. She described what she saw on the video. Resident #51's representative said she witnessed the two CNAs providing assistance to the resident via video recording. She said CNA #5 pulled Resident #51's arm to sit him up in bed and then pulled on both of his arms to have him stand up. She said once as he stood up, CNA #6 got in his face and aggressively yelled a few times at the resident to sit down in his wheelchair. She said CNA #5 said she was going to leave if he did not listen to her. She said CNA #6, who was behind Resident #51, without saying anything yanked on his t-shirt, pulled him backwards and he sat roughly in his wheelchair. D. Record review Resident 51#'s activities of daily living (ADL) care plan, initiated 9/7/23 and revised 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 assistance with dressing and toileting The communication care plan, initiated 10/4/23 and 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 if appropriate using simple, brief and consistent words and cues, using alternative communication tools as needed, speaking on an adult level, speaking clearly and slower than normal and validating message by repeating aloud. III. Staff interviews CNA #2 was interviewed on 5/22/25 at 9:25 a.m. 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. CNA #1 was interviewed on 5/22/25 11:15 a.m. 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. The DON was interviewed on 5/22/25 at 2:30 p.m. The DON said she expected that residents were to be treated with respect and dignity. She said staff was provided education on these topics. She investigated immediately if there was a concern about respect and dignity. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Facility follow-up The NHA was notified of the abuse allegation on 5/21/25 at 11:00 a.m. The NHA said the facility started an investigation and reported the allegation of abuse to the State Agency. She said CNA #5 and CNA #6 were suspended pending investigation, she said the police were notified. The facility investigation documented a family member had provided a video recording of two CNAs assisting Resident #51. The video showed two staff members assisting a resident with the door open and no privacy curtain. The two CNAs were assisting with ADL care, dressing and transferring the resident from the bed to the wheelchair. Staff were giving directions in a loud manner and telling him to' sit down' . When the resident did not, one of the CNAs grabbed the resident's shirt and pulled him back towards the wheelchair, causing the resident to abruptly sit in the wheelchair. The resident immediately stood up and was trying to put shoes on while standing. The facility notified the local law enforcement department. The facility substantiated the allegation of physical abuse by CNA #5 and CNA #6 toward Resident #51.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed ensure residents were free from chemical restraints for one (#18) of five residents out of 32 sample residents. Specifically, the facility failed to ensure Resident #18, who was on an antipsychotic medication, received appropriate and timely monitoring before and after the resident developed signs and symptoms of tardive dyskinesia (involuntary movements). Findings include: I. Professional reference According to the National Institute of Health (NIH) National Library of Medicine's Impact of A Pharmacist-Driven Tardive Dyskinesia Screening Process (7/16/21) retrieved on 6/3/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC8287863/#s1, Tardive dyskinesia is defined as involuntary movements that can develop with prolonged antipsychotic use. Regular monitoring using the Abnormal Involuntary Movement Scale (AIMS) is recommended to be conducted every 3 (three) to 6 (six) months for early recognition, although the AIMS is underused. Several studies have investigated risk factors that may be associated with tardive dyskinesia, including age, sex and long-term antipsychotic use. II. Facility policy and procedure The Psychopharmacological policy and procedure, undated, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:29 p.m. It read in pertinent part, The licensed nurse completes a baseline Abnormal Involuntary Movement Scale (AIMS) on admission, quarterly and as needed if the resident has orders for antipsychotic medications and/or as ordered by the primary care physician or psychiatrist. III. Resident #18 A. Resident status Resident #18, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included depression, vascular dementia, neuroleptic induced parkinsonism (medications side effects that cause symptoms similar to Parkinson's disease a movement disorder) and drug induced subacute dyskinesia (a movement disorder characterized by involuntary repetitive movements). 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. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 5/19/25 at 1:40 p.m. Resident #18 was sitting in her wheelchair and constantly smacking her lips together. C. Record review The antipsychotic medication care plan, initiated 6/4/21, revealed Resident #18 was on antipsychotic medications for the diagnoses of major depression. Interventions included administering psychotropic medication as ordered, AIMS assessment quarterly or as needed, consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly, educating and informing the resident of current medication regimen, observing/documenting and reporting any adverse reactions of psychotropic medication, which included unsteady gait, tardive dyskinesia, shuffling gait, rigid muscle, shaking, frequent falls, refusal to eat, sedation, difficulty swallowing, dry mouth, depression weight gain, edema, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, constipation, muscle cramps, nausea, vomiting and behavioral symptoms. The 9/2/24 AIMS assessment documented the resident had minimal, may be extreme normal facial muscle movement, lip and perioral movement, jaw movement, tongue movement, upper and lower extremity movement, minimal neck, shoulder and hip movement. It documented minimal severity of abnormal movements. Review of Resident #18's electronic medical record (EMR) revealed the facility did not complete any further AIMS assessments (a period of eight months) until 5/20/25 (during the survey), despite the resident exhibiting symptoms of tardive dyskinesia (see below). -Review of Resident #18's May 2025 medication administration record (MAR) and treatment administration record (TAR) revealed there was no documentation regarding monitoring the resident for any adverse reactions or side effects. The May 2025 CPO revealed a physician's order to refer Resident #18 to psychiatry for mouth/lip snacking movements. The physician's order identified the resident was diagnosed with neuroleptic induced parkinsonism with an onset of 3/16/2020 and was currently on Zyprexa (an antipsychotic medication), ordered 4/14/25. The 4/10/25 physician progress note documented possible lip smacking movements were observed which were possibly related to her dementia or antipsychotic medication side effects. Resident #18 had a history of neuroleptic induced parkinsonism would refer to psychiatry for evaluation. The 4/15/25 nursing progress note documented information was provided to the facility's scheduler for an appointment to made for Resident #18 in regards to the referral for mouth/lip smacking movements. The 5/1/25 psychiatric/behavioral health progress documented Resident #18 was on the lowest effective dose of her current antipsychotic medications and the benefits outweighed the risks for the prescribed psychoactive medications. It documented a dose reduction of the medication at that time would only exacerbate the resident's existing symptoms and place the resident at unacceptable risk for harm to self or others. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The note did not address monitoring for worsening tardive dyskinesia. The 5/20/25 AIMS assessment documented the resident had mild facial movement, moderate kp and perioral movement, moderate jaw movement, severe tongue movement, minimal extremity and trunk movement, moderate incapacitation due to abnormal movements. The May CPO failed to reveal an order for antipsychotic medication side effect monitoring. IV. Staff interviews The director of nursing (DON) was interviewed on 5/22/25 at 2:20 p.m. The DON said AIMS assessments should be completed every three months or once a quarter for residents that were on antipsychotic medications. The regional director of clinical services (RDCS) was interviewed on 5/22/25 at 2:55 p.m. The RDCS said AIMS assessments should be completed quarterly (every three months) for anyone on antipsychotropic medications and it was the responsibility of nursing staff to complete the assessments. He said once antipsychotropic medication side effects were identified it should be discussed and addressed with the physician and documented. The DON was interviewed again on 5/22/25 at 4:30 p.m. The DON said AIMS assessments were done quarterly and it was her responsibility to ensure that these were completed. She said the EMR system usually would alert staff when the AIMS assessments were due, but Resident #18's EMR had not alerted staff for the last quarter that the resident's AIMS assessment was due. She said she was currently completing audits on other residents who were on antipsychotic medications to make sure all residents were current with their AIMS assessments. She said it was important to evaluate and monitor residents for side effects of antipsychotic medications and, when concerns were identified, to report those concerns to the physician.

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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** 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents had adequate supervision and assistive devices to prevent accidents for one (#51) of five residents reviewed out of 32 sample residents. Resident #51, who was at risk for falls and had a history of falls, experienced 21 falls between 1/13/25 to 5/15/25. The facility's interdisciplinary team (IDT) met after the falls to determine a root cause for the resident's falls and implement interventions. However, the facility's review of the falls was not always timely. The root cause identified for 19 of the resident's 21 falls was poor safety awareness, however, the facility did not identify a more specific root cause in order to determine if the fall interventions were appropriate and effective for preventing further falls. However, the facility failed to ensure multiple documented interventions were initiated and the resident was observed, during the survey, without several of the observations in place (see observations below). On 4/21/25, the resident experienced a fall which resulted in a laceration to his left eyebrow and a laceration to his chin. He was sent to the emergency department (ED) for evaluation and returned to the facility with five stitches on his left eyebrow and three stitches on his chin. The facility documented an intervention after the 4/21/25 fall for the medical director to review the resident's medication to see if any medications were possibly contributing to the resident's falls. However, there was no documentation to indicate this was completed and the resident continued to experience falls. Specifically, the facility failed to consistently review Resident #51's falls in a timely manner, identify specific root causes of the falls and ensure documented interventions were initiated and consistently in place. Findings include: I. Facility policy and procedure The Fall Management policy and procedure, dated 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, A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Interventions are to be re-evaluated when a resident falls for efficacy. Document in the electronic medical record (EMR) the resident's response to interventions and revise interventions if they were not successful. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	II. Resident #51 A. Resident status Resident #51, age [AGE], 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. The MDS assessment indicated the resident had had two or more falls since his prior assessment. B. Observations On 5/19/25 at 10:10 a.m. Resident #51's door was open. He was in bed, however, the resident's call light was on the floor behind his headboard. Resident #51 slowly rolled to the edge of the bed to reach for his call light. The resident had to stretch and roll close to the edge of his bed to reach the call light. He pushed the call light for assistance to reposition himself. An unidentified certified nurse aid (CNA) responded and asked from the doorway what Resident #51 needed. Resident #51 was difficult to understand. 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 notice the resident's close proximity to the edge of the bed. Observations of Resident #51's room on 5/19 at 10:10 a.m. did not reveal a helmet, grip tape on the resident's floor or a call don't fall sign in the resident's room (see care planned fall interventions below). C. Resident interviews Resident #51 was interviewed on 5/19/25 at 10:00 a.m. He said he had many falls and does not always use the call light because it was not answered in a timely manner. He said he had waited at least 45 minutes or more before anyone came in to help him. Cross-reference F550 for failure to respond to call lights in a timely manner. Resident #51 was interviewed a second time on 5/22/25 at 1:00 p.m. He said he did not know where his helmet was. D. Resident representative interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #51's representative was interviewed on 5/21/25 at 10:50 a.m. Resident #51's representative said she had witnessed staff (via a camera in the resident's room) leaving Resident #51 standing in his room alone and shutting the door. She said Resident #51 had a floor to ceiling transfer pole that was removed a couple of months ago. Resident #51's representative said she and the resident's other representative had requested the transfer pole be reinstalled because the resident had had more falls since the pole was removed. Resident #51's representative said the resident would go many hours before a staff member checked on him. E. Record review The at risk for falls care plan, initiated 9/7/23 and revised 4/15/25, revealed Resident #51 was at risk for falls related to his progressive supranuclear ophthalmoplegia and history of falls. He had unsteady balance during transfers. Resident #51 became frozen (temporary inability to move) and had a hard time processing what he needed to do next. Resident #51 preferred to keep his room dark and preferred to not wear socks and shoes. Pertinent interventions included ensuring the resident's call light was within reach and encouraging him to use it, promptly responding to all requests for assistance, placing a call don't fall sign in the resident's room, frequent rounding, placing grip tape on the floor near the resident's bed, physical therapy (PT) to evaluate and treat as ordered or needed, checking the resident after meals for toileting, snacks and hydration and reminding Resident #51 to lock his wheelchair brakes, ask for assistance to change the room temperature and clean up spills. Review of Resident #51's electronic medical record (EMR) revealed the resident had 21 falls from 1/13/25 through 5/15/25. Review of Resident #51's falls between 1/13/25 and 5/15/25 revealed the following: 1. Fall incident on 1/13/25 - unwitnessed The 1/13/25 fall investigation documented Resident #51 was lying on the floor next to the bed, naked with dried blood over his left eyebrow. Resident #51 said he fell during the night. The resident's eyebrow was cleaned with saline and steri-strips were applied. The IDT risk management review note, dated 1/21/25, documented the root cause was poor safety awareness and a diagnosis of progressive supranuclear ophthalmoplegia. The intervention was to offer a helmet. -However, a helmet was not observed in the resident's room during the survey (see observations above). -The IDT risk management review of the fall was not completed until eight days after the fall and after Resident #51 had sustained another fall on 1/15/25 (see below). 2. Fall incident on 1/15/25 - unwitnessed (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/15/25 fall investigation documented Resident #51 was sitting on the floor by the dresser. The wheelchair was away from him and the wheelchair brakes were not on. Resident #51 said he was fixing stuff on top of his dresser. The resident had no injury. The IDT risk management review note, dated 1/21/25, documented the root cause was poor safety awareness and the resident's wheelchair brakes were unlocked. The intervention was to add anti-rollback devices to the resident's wheelchair. -The IDT risk management review of the fall was not completed until six days after the fall. 3. Fall incident on 1/21/25 - unwitnessed The 1/21/25 fall investigation documented Resident #51 was sitting at the bathroom door with fecal matter smeared across the floor and his hands. Resident #51 had an abrasion on his left shoulder. Resident #51 said he fell.The IDT risk management review note, dated 1/23/25, documented the root cause was diagnosis of progressive supranuclear ophthalmoplegia and poor safety awareness. The intervention was to remind Resident #51 to call for assistance, motion sensor lights in the room and increased rounds. -The IDT risk management review of the fall was not completed until two days after the fall 4. Fall incident on 2/10/25- unwitnessed The 2/10/25 fall investigation documented Resident #51 was sitting on the floor with his wheelchair in front of him and his legs under the wheelchair. Resident #51 said he was not hurt. Resident #51 had a scratch to the skin on his back. The IDT risk management review note, dated 2/10/25, documented the root cause was poor safety awareness. The intervention was to remind Resident #51 to lock his brakes before standing from his wheelchair. 5. Fall incident on 2/11/25 - unwitnessed The 2/11/25 fall investigation documented Resident #51spilled a pitcher of water, slipped and fell in his room. The resident had no injury. The IDT risk management review note, dated 2/23/25, documented the root cause was the wet floor. Interventions were to ensure the floor was free from spills and remind Resident #51 to notify staff immediately of spills so they could be cleaned up. -The IDT risk management review of the fall was not completed until ten days after the fall. 6. Fall incident on 2/24/25 - unwitnessed The 2/24/25 fall investigation documented Resident #51 was sitting on the floor holding the transfer pole with his helmet on. Resident #51 said he fell from his wheelchair. The resident had no injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The IDT risk management review note, dated 3/5/25, documented the root cause was poor safety awareness and a diagnosis of progressive supranuclear ophthalmoplegia. The intervention was to conduct more frequent rounds. -The IDT risk management review of the fall was not completed until nine days after the fall and after the resident had sustained another fall on 2/25/25 (see below). 7. Fall incident on 2/25/25 - unwitnessed The 2/25/25 fall investigation documented Resident #51 was sitting on the floor behind his door. Resident #51 said he fell. The resident had no injury. The IDT risk management review note, dated 3/5/25, documented the root cause was poor safety awareness and a diagnosis of progressive supranuclear ophthalmoplegia. The intervention was to encourage the resident to wear shoes or grip socks when out of bed or with transfers. -The IDT risk management review of the fall was not completed until eight days after the fall. 8. Fall incident on 3/16/25 - unwitnessed The 3/16/25 fall investigation documented Resident #51 was lying on his right side in the center of his room. Resident #51 said he wanted to get up. The resident had no injury. The IDT risk management review note, dated 3/18/25 documented the root cause was poor safety awareness. The intervention was to educate the Resident #51 on the use of his call light when he needed assistance and to put his shoes on before getting out of bed. -The IDT risk management review of the fall was not completed until two days after the fall. 9. Fall incident on 3/21/25 - unwitnessed The 3/21/25 fall investigation documented Resident #51 was sitting on the floor in his room near his refrigerator. Resident #51 said he was trying to open the refrigerator. The resident had no injury. The IDT risk management review note, dated 4/7/25, documented the root cause was poor safety awareness. The interventions were rounding or answering his call light, encouraging Resident #51 to inform staff of all his needs so he would not need to get up independently. -The IDT risk management review of the fall was not completed until 17 days after the fall. 10. Fall incident on 3/24/25 - unwitnessed The 3/24/25 fall investigation documented Resident #51 was sitting on the floor, wearing only a shirt, by the side of the bed. It appeared as though Resident #51 lost his balance and fell/sat down after using the bathroom. The area next to his bed was frequently wet from Resident #51 urinating in the trash can. Resident #51 said he sat down on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The IDT risk management review note, dated 4/15/25, documented the root cause was poor safety awareness. The intervention was to encourage Resident #51 to not sit on the floor and take rest breaks when tired. -The IDT risk management review of the fall was not completed until 22 days after the fall. 11. Fall incident on 4/8/25 - unwitnessed The 4/8/25 fall investigation documented Resident #51 was standing up holding on to his dresser and fell. Resident #51 did not explain why he was standing holding on to the dresser or how he fell. He hit his head on the door. The IDT risk management review note, dated 4/8/25, documented the root cause was the diagnosis of progressive supranuclear ophthalmoplegia and poor safety awareness. The intervention was to encourage the dresser to be moved. 12. Fall incident on 4/10/25 - witnessed by family member The 4/10/25 fall investigation documented Resident #51 was outdoors with his sister and he fell out of his wheelchair. Resident #51's sister explained he was not well positioned in his chair. There was a bruise on his left knee. The IDT risk management review note, dated 4/11/25, documented the root cause was poor safety awareness. The intervention was to educate family when they took Resident #51 out of the building to ensure he was properly seated in the wheelchair. 13. Fall incident on 4/11/25 - unwitnessed The 4/11/25 fall investigation documented Resident #51 was sitting on the floor by his bed and he was not wearing shoes. Resident #51 said he wanted to get up. The resident had no injury. The IDT risk management review note, dated 4/11/25, documented the root cause was poor safety awareness and the diagnosis of supranuclear ophthalmoplegia. The intervention was placing grip tape on the floor near the bed. -However, observation during the survey revealed there was no grip tape on the resident's floor (see observations above). 14. Second fall incident on 4/11/25 - unwitnessed The 4/11/25 fall investigation documented Resident #51 was sandwiched between the closed bathroom door and his wheelchair. Resident #51 could not tell how he ended up behind the wheelchair. The resident had no injury. The IDT risk management review note, dated 4/11/25, documented the root cause was the diagnosis of supranuclear ophthalmoplegia and poor safety awareness. The intervention was to place a call don't fall sign in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However, observations during the survey revealed there was no call don't fall sign posted in his room (see observations above). 15. Fall incident on 4/17/25 - witnessed The 4/17/25 fall investigation documented Resident #51 was leaning towards his night stand to place a water pitcher when he leaned forward, hitting his stomach against the night stand and lost his balance. He fell onto his left side without hitting his head. He had a skin tear to his left knee, pain rated at a 5 out of 10 to the left knee and a small bruise on his abdomen. He had Xrays taken of his left hip and lumbar spine, which were negative for any injury. The IDT risk management review note, dated 4/18/25, documented the root cause was poor safety awareness and the diagnosis of progressive supranuclear ophthalmoplegia. The intervention was the dresser was moved. -However the intervention was documented for the 4/8/25 fall (see above) and not completed until 4/18/25. 16. Fall incident on 4/19/25 - unwitnessed The 4/19/25 fall investigation documented Resident #51 was sitting and holding the bathroom door handle in his left hand. Resident #51 did not say how he fell. He had redness on the left elbow. The IDT risk management review note, dated 4/24/25, documented the root cause was poor safety awareness. The intervention was to review history on the resident's previous falls to track trends. Resident #51 fell multiple times of day and the falls tended to be between meals. Staff was to check on the resident after meals to see if he needed toileted, snacks or hydration. -The IDT risk management review of the fall was not completed until five days after the fall and after the resident had sustained another fall on 4/21/25 (see below). 17. Fall incident on 4/21/25 - unwitnessed The 4/21/25 fall investigation documented Resident #51 was sitting on the floor between the doorway and the wheelchair was to his left. Resident #51 said he was trying to get to the doorway to stand up and hold on. Resident #51 had a laceration to his left eyebrow and a laceration to his chin. He was sent to the ED for evaluation. Resident #51 returned with five stitches on his left eyebrow and three stitches on his chin. The IDT risk management review note, dated 4/25/25, documented the root cause was poor safety awareness. The intervention was to refer to the medical director for review of Resident #51's medications to determine if any medications were contributing to the resident's falls. -The IDT risk management review of the fall was not completed until four days after the fall and after the resident had sustained another fall on 4/24/25 (see below). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Additionally, there was no documentation to indicate the facility had notified the medical director to review the resident's medications and/or what the findings of the review were if it was completed. 18. Fall incident on 4/24/25 - unwitnessed The 4/24/25 fall investigation documented Resident #51 was on the floor behind the door which prevented staff from fully opening the door. The wheelchair was tipped over on its side and leaning on the resident. Resident #51 was unable to provide a description of the fall. The resident had no injury. The IDT risk management review note, dated 4/28/25, documented the root cause was poor safety awareness and disease process. The intervention was to offer hipsters, which Resident #51 declined, and the use of a helmet. -However, the helmet had been identified as an intervention after the resident's fall on 1/13/25 (see above) and a helmet was not observed in the resident's room during the survey (see observations above). -The IDT risk management review of the fall was not completed until four days after the fall. 19. Fall incident on 5/7/25 - unwitnessed The 5/7/25 fall investigation documented Resident #51 was behind the door in his room. The resident had urinated on the floor and slipped on the urine when he tried to transfer from bed to chair. The urinal was not within reach. Resident #51 said he tried to transfer from his bed to the wheelchair. The resident had no injury. The IDT risk management review note, dated 5/9/25, documented the root cause was poor safety awareness and the diagnosis of progressive supranuclear ophthalmoplegia. The intervention was to keep the urinal near the resident on the trash can, per resident preference. -The IDT risk management review of the fall was not completed until two days after the fall and after the resident had sustained another fall on 5/8/25 (see below). 20. Fall incident on 5/8/25 - unwitnessed The 5/8/25 fall investigation documented Resident #51 was sitting in the hallway by his room. Resident #51 was unable to give a description of what happened. The resident had no injury. The IDT risk management review note, dated 5/9/25, documented the root cause was poor safety awareness and progressive supranuclear ophthalmoplegia. The intervention was to educate the resident to utilize his wheelchair and keep it near him when he stood up and not to walk away from it. 21. Fall incident on 5/15/25 - unwitnessed The 5/15/25 progress note documented the resident was found on the floor. The resident had no injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-There was no IDT risk management review documented for the fall. -Out of Resident #51's 21 reviewed falls, the facility documented the same root cause for 19 of the falls. There was no follow up documentation to indicate what interventions had been successful or why an intervention was discontinued. III. Staff interviews CNA #3 was interviewed 5/20/25 at 3:45 p.m. CNA #3 said the Kardex (quick reference guide for patient care), which was on the computer, informed staff about who was a fall risk. CNA #3 said Resident #51's wellness varied from day to day and on bad days he needed more assistance with his activities of daily living (ADL) and transfers. He said the resident used his call light at times. CNA #3 said Resident #51 was a fall risk and she tried to check on him every one to one and a half hours. CNA #2 was interviewed on 5/22/25 at 9:25 a.m. CNA #2 said she knew a resident was a fall risk if there was a fall mat in the room or the bed was in the lowest position. CNA #2 said she was notified of fall risks in morning report. She said if a resident was a fall risk, staff should check on the resident at least every two hours and if they were a high fall risk, staff should check on the resident every 30 minutes to an hour. CNA #2 said she documented it when she checked on a resident, however, she could not find that documentation on the computer. She said the Kardex was on the computer, but she did not carry a paper copy with her The NHA was interviewed on 5/22/25 at 2:08 p.m. The NHA said there was no specific fall committee who reviewed resident falls. She said falls, root causes and interventions were discussed every morning at the department head meeting. She said there was no floor staff present at the meetings. The NHA said if fall interventions did not work, the intervention would be discontinued and resolved on the care plan. She said Resident #51 had a transfer pole in his room but it had been removed because it was identified as contributing to his falls. The NHA said the resident had had less falls since the removal of the transfer pole on 3/18/25. The NHA said there had not been a recent referral to PT or occupational therapy (OT) for Resident #51, however, she said a therapy referral would be appropriate for the resident due to all of his falls. -However, Resident #51 had nine falls from 1/13/25 to 3/16/18 and 12 falls from 3/18/25 through 5/15/25. There was no documentation in the EMR why the pole was removed or the effectiveness of removing this intervention. Resident #51's representative requested the transfer pole back on 4/11/25. The care plan had an intervention of referring to PT as indicated. The director of nursing (DON) was interviewed on 5/22/25 at 4:07 p.m. The DON said falls were discussed at the department head meeting every morning. She said the meeting did not include floor staff. She said she or the NHA communicated any changes related to residents' fall interventions that were discussed in the department head meeting to the floor staff. The DON said she expected the floor staff to verbally notify in-coming shifts of any changes to residents' fall interventions. The DON said the floor staff were responsible for logging onto the computer to look for communications related to resident changes which had been posted by her or the NHA. The DON said she did not monitor when floor staff checked the computers for the updates. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON said that if frequent checks were an intervention, ideally those would be completed every 15 minutes, but residents should be checked on at least every hour. She said the nurses and CNAs were to perform the frequent checks. The DON said there was no documentation system in place to track if frequent checks were completed.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the necessary mental health care and services to attain or maintain the highest practicable physical, mental and psychosocial well being for one (#16) of three residents reviewed for mental health out of 32 sample residents. Resident #16, was admitted on [DATE] and readmitted on [DATE], with diagnoses of bipolar disorder and dissociative disorder. The resident had a previous reported history of suicidal ideation with self-harm. Resident #16 had documented behaviors of becoming easily agitated, verbally reactive and frequently calling emergency medical services (EMS) for all issues. Resident #16 had a behavioral care plan in place, which included monitoring mood/behavior and consulting with behavioral health services. However, the resident did not have a safety plan in place based on a past history of making suicidal ideations or triggering behaviors when her manic behaviors were escalating, including exhibiting an inability to sleep, crying and becoming easily agitated. On 2/4/25 Resident #16 self-inflicted cuts to her wrists with a pair of scissors after spending 45 minutes on the phone with the mental health crisis center. Resident #16 was sent to the hospital for her suicidal ideation and attempt to cut her wrists with scissors. Resident #16 returned from the hospital on 2/13/25 with a safety plan that included identifying warning signs, identifying internal coping strategies, identifying people and social settings that provided distraction and identifying people to ask for help during crisis, making the environment safer with no access to firearms, no access to medications and removing scissors out of her room and giving them to staff. -However, the facility failed to include the crisis/safety plan interventions in the care plan after the resident returned to the facility on 2/13/25. On 2/22/25 Resident #16 called the mental health crisis center again and asked them to call EMS for her. She told the mental health crisis center she did not feel safe and felt like killing herself. Resident #16's room was checked by facility staff for sharp objects and she was sent to the hospital for suicidal ideation. Resident #16 returned from the hospital approximately five hours later and the facility progress notes documented a safety plan was in place. -However, the facility again failed to include the crisis/safety plan interventions in the care plan after Resident #16's return from the hospital for the second incident of suicidal ideation in less than one month. On 3/16/25 the facility again received a call from the mental health crisis center informing the facility that Resident #16 was having suicidal ideations. The nurse went to check on Resident #16 who was on the back patio with a pair of black scissors held to her left wrist and the resident had self-inflicted superficial cuts to her left wrist with a small amount of blood present. The nurse removed the scissors, placed the resident on one-to-one supervision and called the physician and EMS. The resident was transported to the hospital and admitted for suicidal ideation and bipolar mood disorder. The resident returned from the hospital on 3/27/25 after being determined to be medically and psychiatrically stable. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A safety plan was not initiated and coordinated with behavioral health and interventions placed in the care plan until 4/2/25, Resident #16's third incident of suicidal ideation and her second attempt to cut her wrist with scissors in less than six weeks. Specifically, the facility failed to coordinate and implement timely person-centered behavioral and safety interventions which resulted in Resident #16 experiencing three incidents of suicidal ideation on 2/4/25, 2/22/25 and 3/16/25 and two attempts to cut her wrists with scissors on 2/4/25 and 3/16/25. Findings include: I. Facility policy and procedure The Behavioral Health Services policy and procedure, revised February 2019, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:29 p.m. It read in pertinent part, The facility will provide, and residents will receive, behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. Staff training regarding behavioral health services includes, but is not limited to recognizing changes in behavior that indicate psychological distress; implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; monitoring care plan interventions and reporting changes in condition; protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post traumatic stress disorder. II. Resident #16 A. Resident status Resident #16, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, dissociative identity disorder and suicide attempts. The 4/29/25 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 was independent with eating, toileting, personal hygiene, bed mobility and transfers. The MDS assessment indicated she did not exhibit behaviors of little interest and pleasure in doing things or feeling down and depressed or hopeless. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-The safety plan was not implemented until 4/1/25, after Resident #16 experiencing three incidents of suicidal ideation on 2/4/25, 2/22/25 and 3/16/25 and two attempts to cut her wrists with scissors on 2/4/25 and 3/16/25 (see record review below). -A comprehensive review of the care plan failed to identify Resident #16 was no longer using the wanderguard or allowing a camera in her room for additional monitoring (see interviews below). -The care plan additionally failed to identify frequent 15-minute checks as the increased monitoring intervention for the resident's safety (see interviews below). The May 2025 CPO revealed a physician's order to document Resident #16's target behaviors and the interventions attempted and their effectiveness. Target behaviors included suicidal ideation, mood fluctuations with anxiety and attention seeking. Interventions to be documented included redirection, one-to-one, diversional activity, offer to call family or friends and reassurance and check for respiratory distress, ordered 12/6/24. The 1/29/25 behavioral health screening progress note documented an initial assessment regarding Resident #16's depression related to medical issues, anxiety disorder and insomnia. It documented therapeutic interventions to assist processing through thoughts and feelings. It documented assisting with reality orienting skills and pro-social skills. It documented Resident #16 was a strong advocate for her needs. The 2/3/25 behavioral health psychotherapy progress note documented therapeutic interventions to assist processing through thoughts and feelings. It documented assisting with reality orienting skills and pro-social skills. It documented the plan was to provide therapeutic and case management support and for the resident to be seen by the nurse practitioner. The 2/4/25 at 7:36 p.m. change of condition nursing progress note documented Resident #16 had cut her wrist with a pair of scissors and EMS was called for transfer of the resident to the hospital. The 2/4/25 at 11:16 p.m. nursing progress note documented Resident #16 was sent to the hospital at 7:15 p. m. via EMS for cutting her wrists. (continued on next page)

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Rowan Community, Inc	4601 E Asbury Cir Denver, CO 80222

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The 2/5/25 at 12:32 a.m. nursing behavior progress note documented that at 6:40 p.m. Resident #16 returned from the outside patio to her room and was on the phone talking to the mental health crisis center. The nurse then spoke with the crisis center and the crisis center told her that they had been on the phone with Resident #16 for 45 minutes because the resident had told the them she was suicidal. The nurse told the crisis center Resident #16 had not told staff at the nursing home that she was suicidal but she was now aware and would help Resident #16. Resident #16 screamed at the nurse that she was going to kill herself. The nurse asked the resident how she was planning on doing that. Resident #16 said she would do it with scissors. The nurse asked if Resident #16 had scissors and did not get a response from Resident #16. The nurse checked the resident's drawers, tables and her walker seat and pouch and asked for Resident #16 to check behind her. Resident #16 refused and threw the remote control to the television and a shoe at the nurse. The nurse called Resident #16's representative and Resident #16 refused to speak with her. The nurse then notified Resident #16's representative that Resident #16 needed to go to the hospital. The nurse called EMS from the nurses station and was placed on hold. While the nurse was on hold with EMS, Resident #16 was heard screaming that she had cut herself. The nurse hung up the phone, went to Resident #16's room and found her bleeding from her left wrist with a pair of scissors in her right hand. The nurse removed the scissors and asked a certified nurse aide (CNA) to stay with the resident. The nurse dressed the cut and applied pressure to the wrist, stayed with Resident #16 and called EMS from her personal cell phone. EMS arrived at 7:10 p.m. and transported Resident #16 to the emergency room. -Resident #16 was not placed on one-to-one supervision or kept in direct line of sight while the nurse called EMS, despite the resident having just threatened to cut herself with scissors. The 2/7/25 interdisciplinary team (IDT) risk management progress note documented Resident #16 had a self-inflicted injury with the root cause identified as an exhibited behavior after the resident's daughter did not come to the facility as she had stated she would. The 2/13/25 hospital discharge summary documented Resident #16 was admitted to the hospital wth suicidal ideation. The summary documented a safety plan that included identifying warning signs, identifying internal coping strategies, identifying people and social settings that provide distraction, and identifying people to ask for help during crisis, making the environment safer with no access to firearms, no access to medications and removing scissors out of her room and giving them to staff. It documented the resident was to follow up with the behavioral health care provider for an appointment on 2/14/25 for medication management and therapy. -However, there was no documentation in the resident's EMR to indicate the resident was seen by her behavioral health care provider on 2/14/25. The 2/13/25 hospital discharge crisis plan, signed by Resident #16 on 2/12/25, included ways for the resident to stay well, prevention measures to stay well, identification of warning signs, strategies to take her mind off negative thoughts and identification of people she would be willing to ask for help. -However, the crisis safety plan was not initiated on the resident's care plan upon the resident's return to the facility on 2/13/25 (see care plan above). A comprehensive review of the EMR failed to reveal documentation of a follow up with the behavioral health provider. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The 2/22/25 behavioral nursing progress note documented nursing staff received a call from EMS at 7:35 p. m. to notify staff that EMS had received a call from Resident #16 and to check on her. Nursing staff found Resident #16 outside crying and on the phone to the mental health crisis center. She said she wanted to kill herself, she was not being treated for her depression and she felt unsafe. Resident #16 asked the crisis center to call EMS for her again. The facility nurse checked Resident #16's belonging for sharp items and was unable to locate any. Resident #16 hung up the phone and was calm and told nursing staff the paramedics were coming to get her. EMS arrived at 7:53 p.m. and transported the resident to the hospital. The 2/23/25 at 2:19 a.m. nursing progress notes documented Resident #16 had returned from the hospital at 1:52 a.m. with a safety plan. -However, the safety plan was not initiated on the resident's care plan upon the resident's return to the facility on 2/23/25 (see care plan above). The 3/16/25 nursing progress documented Resident #16 was sent to hospital at 4:30 p.m. due to attempting suicidal acts. -However, a review of the resident's electronic medical record (EMR) revealed there was no documentation of the incident prior to the resident being transported to the hospital. The 3/16/25 facility investigation documented the facility received a call from the mental health crisis center informing them that Resident #16 was having suicidal ideations. The facility nurse went to check on Resident #16 who was on the back patio with a pair of black scissors held to her left wrist and she had self-inflicted superficial cuts to her left wrist with a small amount of blood present. The nurse removed the scissors, placed the resident on one-to-one supervision and called the physician and EMS. The 3/20/25 hospital psychiatric progress note documented Resident #16 was hospitalized with a brief suicidal ideation and documented the resident's bipolar symptoms were improved and, from a psychiatric standpoint, she was no longer a danger to herself and she could return to facility. Recommendations were to continue with her current behavioral health provider The 3/27/25 hospital discharge summary documented Resident #16 presented to the emergency room with mood disorder and past attempts with suicidal ideation. Resident #16 was being followed by psychiatry, suicide precautions were discontinued and she was deemed stable to return to the facility. The 3/29/25 preadmission screening and referral program (PASRR) Level II evaluation documented Resident #16 was medically and psychiatrically stable before discharge from the hospital. It documented she had a significant history of suicidal ideation and attempts. The recommended specialized services were psychiatry case consultation, individual therapy, crisis intervention/individual safety plan, additional one-on-one engagement support and other services, including peer mentor, intensive outpatient program (IOP), and referral to the transitions program. The 4/2/25 psychosocial/social services note documented the behavioral health provider met with the facility's social worker and a clinician to discuss an action plan to prevent Resident #16 from harming herself. The plan was placed in the resident's chart. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The behavioral health crisis action plan, signed by Resident #16 on 4/2/25, documented identification of triggers that were a cue for unhealthy or ineffective behaviors which included mania that made it difficult to sleep at night, anxiety and depression such as crying, heart racing, tending to blame others and no energy. It documented identification of personal warning signs such as heart racing, crying and losing sleep. It documented interventions for Resident #16 to keep her environment safer, such as going outside when the weather was cold, removing access to scissors and other sharp objects and going to activities. It documented intervention to promote well being, such as writing in a gratitude journal, attending group activities and going on outings with children. It identified people that could provide support for Resident #16. The 4/4/25 IDT risk management progress note documented Resident #16 was sent to the hospital (on 3/16/25) and the root cause was behavioral. A comprehensive review of Resident #16's EMR failed to reveal behavioral provider notes from immediately after the 2/4/25, 2/22/25 or the 3/16/25 incidents. The May 2025 CPO documented a physician's order for a wanderguard to prevent Resident #16 from going out of the facility unassisted, ordered 3/31/25 and discontinued 4/4/25. The May 2025 CPO further documented a physician's order for a wanderguard to prevent Resident #16 from leaving the facility unassisted, to be kept on her walker not her person, ordered 4/4/25 and discontinued 5/15/25. A review of Resident #16's frequent 15-minute check monitoring sheets, beginning 3/31/25 and ending 5/17/25, failed to reveal documentation of frequent monitoring of the resident on the following days: 4/4/25, 4/6/25, 4/7/25, 4/8/25, 4/9/25, 4/18/25 and 5/13/25. A comprehensive review of Resident #16's EMR did not reveal suicide risk assessments before the resident's 2/22/25 3/16/25 suicide attempts. III. Staff interviews RN #2 was interviewed on 5/21/25 at 10:36 a.m. RN #2 said Resident #16 escalated easily and reacted verbally. She said she did not observe the resident's suicidal behaviors but she had heard about the resident using scissors to cut her wrists. She said she was not sure where the resident had found the scissors. She said staff tried to do frequent checks of her room but it was difficult because staff were not allowed to search or remove anything from a resident's room without permission from the resident. She said nursing staff had been checking Resident #16 frequently for a while and she was on frequent 15-minute checks indefinitely due to her behaviors. She said the staff documented the monitoring on a paper form that she kept on her cart and it was turned in to medical records after it was filled out. She said Resident #16 used to have a wanderguard but the resident removed it from her walker and did not want it. She said staff had tried to install a camera in her room but she removed it and did not want it reinstalled. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/21/25 at 1:45 p.m. The DON said Resident #16 had a long standing history of behaviors where she would call EMS when she became angry, anxious or things were not going her way. She said they had witnessed, on camera, her throwing herself on the floor. She said recently Resident #16 had been experiencing shortness of breath and chest pain because of her chronic obstructive pulmonary disease (COPD) and she had threatened to kill herself. She said Resident #16 had called the mental health crisis center and notified them of her suicidal ideations without telling the staff. She said Resident #16 also called EMS frequently on her own for multiple things. She said the frequent EMS calls by Resident #16 had gotten so bad that EMS would no longer automatically come to the facility. The DON said Resident #16 had been seen by a behavioral health care provider but had started a new behavioral provider less than a year ago that she preferred. She said Resident #16 would no longer allow the wanderguard or the camera in her room and staff should be doing frequent checks and documenting the checks. She said there was behavioral monitoring in place for the resident's triggers to try to capture behaviors before she escalated and started calling EMS. She said Resident #16 called EMS for perceived medical issues, not just mental health issues. She said her triggering behaviors when she was escalating were crying, not sleeping, screaming at staff and blaming others. She said the care plan and the safety plan should reflect what current interventions were in place. The DON said when Resident #16 did make suicidal ideations to staff, it should be taken seriously and the resident should be kept safe. She said the resident's suicidal ideations should trigger a suicide risk assessment to determined resident's risk and if the resident had a plan to kill herself. She said it was unclear where Resident #16 had obtained the scissors she used to cut her wrists on 2/4/25 and 3/16/25. She said staff thought she may have obtained a pair of sewing scissors from a roommate. She said she was no longer roommates with that resident. She said another pair of scissors may have been obtained from a drawer at the front desk. She said since the incident, staff now had been locking that drawer. The DON said the facility tried putting Resident #16 in a room closer to the nurses' station but she had not liked her roommate and she had to be moved to another room. She said a camera was now in place on the patio in order to monitor her because Resident #16 had demonstrated behaviors, such as calling EMS and the mental health crisis and had one of her suicidal attempts on the patio. The licensed clinical social work mentor was interviewed on 5/22/25 at 11:45 a.m. The licensed clinical social work mentor said the facility had not had a social worker for about a month but had hired a social work assistant a few weeks ago. She said after review of Resident #16's medical record, she was unable to determine if a safety plan was in place prior to the current one that was initiated on 4/2/25. She said she was unable to determine what communication was being provided by the behavioral health care providers to the facility in order to manage the resident's behaviors and her suicidal ideations. The licensed clinical social work mentor said moving forward, she was formulating a tracking tool to document when the behavioral health care providers were in the building and obtaining their notes to better enhance communication between the facility and the providers. The licensed clinical social work mentor said she had reached out to the behavioral health providers but had not received communication from them yet regarding the visit documentation for Resident #16. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The NHA, who was a social worker, was interviewed on 5/22/25 at 11:55 a.m. The NHA said Resident #16 had been seeing a different behavioral health care provider prior and had started with the current provider less than a year ago. She said when a resident presented with suicidal ideations, there was a form in the EMR that walked staff through the assessment process to determine the resident's risk for suicide. She said all of Resident #16's current interventions for behaviors and the safety care plan should be updated and current with documented triggering behaviors. IV. Facility follow up On 5/24/25 at 2:52 a.m., after the survey exit, the licensed clinical social work mentor provided the following behavioral health documentation: The 3/5/25 community treatment and management (CTT) progress note documented that Resident #16 was having difficulty with insomnia due to bipolar and exacerbating her depression. It documented an increase of her antipsychotic medication (Apripiprazole) and starting trazodone (an antidepressant that also helps with insomnia). -However, the resident returned from the hospital on 2/23/25 and the note was not written until 3/5/25, 10 days after the resident's return to the facility. The 3/18/25 CTT progress note documented Resident #16 was currently hospitalized after a witnessed suicidal gesture she made in front of staff. It documented consultation with an inpatient psychiatrist and discussed a plan of care and adjustment to medication. The psychiatrist had attempted referral to inpatient psychiatric units but due to the resident being dependent on oxygen, she was unable to be admitted to inpatient units. The 4/2/25 CTT progress note documented a solution focused brief therapy note. It documented a recent suicide attempt where Resident #16 cut her wrists with scissors. It documented a well being action plan. It documented a wanderguard to prevent her from leaving the facility unsupervised. -However, the resident returned from the hospital on 3/27/25 and the note was not written until 4/2/25, six days after the resident's return to the facility. The 4/2/25 psychiatry evaluation and management progress note documented Resident #16 was diagnosed with bipolar disorder. Resident #16 was currently on Seroquel (an antipsychotic medication) that was prescribed during her hospitalization on 3/16/25. The resident was reporting better sleep and a good appetite. The 4/29/25 CTT progress note documented Resident #16's mood appeared more stabilized and she reported being hopeful. It documented there were no recent attempts of suicide. It documented Resident #16 no longer had a wanderguard or video camera in the room. Resident #16 said she had discussed it with the NHA and it had been collaboratively decided to remove them. -The note failed to identify what intervention was put in place of the wanderguard and camera to monitor and keep the resident safe. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	-The documentation provided by the licensed clinical social work mentor after the survey exit additionally failed to reveal documentation to indicate Resident #16 was seen by her behavioral health care provider on 2/14/25, after her first hospitalization for suicide attempt, as was documented in the 2/13/25 hospital discharge summary (see record review above).

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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** 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 [AGE], 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 20 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** 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** 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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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.