STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065213	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide activities designed to support residents' physical, mental and psychosocial well-being were provided for one (#10) of four residents reviewed for meaningful activity programming activities out of 32 sample residents and on one of three units.Specifically, the facility failed to:-Offer and provide a personalized activity program for Resident #10;-Ensure Resident #10 was invited and encouraged to attend activities of the resident's preference; and,-Ensure a meaningful activities program was consistently provided to residents residing in the facility's secured dementia care unit.Findings include: I. Facility policy and procedure The Activities policy, revised 3/24/26, was provided by the nursing home administrator (NHA) on 3/31/26 at 11:47 a.m. It revealed in pertinent part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident as well as support their physical, mental, and psychosocial well-being. Each resident's interest and needs will be assessed on a routine basis, including activity assessments to identify resident preferences and needed adaptations. Activities will include individual, small and large group activities as well as individualized activities. II. Failed to offer and provide a personalized activity program for Resident #10 and ensure the resident was invited and encouraged to attend activities of the resident's preference A. Resident status Resident #10, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included dementia with agitation, frontotemporal neurocognitive disorder (affects behavior and ability to participate in care) and history of falling. The 1/2/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. He required substantial assistance with eating, walking, bathing and dressing. B. Observations On 3/23/26 at 9:40 a.m. Resident #10 was sitting in a reclining chair by the nurses' station. There (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were several other residents next door in the common area who were participating in activities and some residents were watching television. Registered nurse (RN) #2 was at the nurses' station and did not offer to see if Resident #10 wanted to participate in activities. On 3/23/26 at 1:24 p.m. Resident #10 was sitting at the nurses' station napping while other residents were next door in the common area watching television. There were two staff members present at the nurses' station, including RN #2, who were seated nearby. -No staff members engaged with Resident #10 or offered activities to the resident. On 3/23/26 at 4:09 p.m. Resident #10 was sitting by the nurses' station in the recliner chair with periods of being asleep and awake. -No staff members engaged with Resident #10 or offered activities to the resident. On 3/24/26 at 8:48 a.m. Resident #10 was sitting at the nurses' station in a recliner while other residents participated in activities next door in the common area. Resident #10 was positioned next to the wall. The wall blocked his view of the common area and he was unable to participate passively in the activity. On 3/24/26 at 11:02 a.m. Resident #10 was sitting in the recliner chair near the nurses' station holding one of his shoes in his hand, with the other shoe positioned underneath his right thigh. There were several other residents in the room next to him who participated in activities using a balloon and hitting it back and forth with the activity staff. -No staff members engaged with Resident #10 or offered for the resident to participate in the balloon activity. During a continuous observation of Resident #10 on 3/24/26, beginning at 12:23 p.m. and ending at 3:25 p.m., the following was observed: At 12:23 p.m. Resident #10 was sitting in a recliner by the nurses' station with no engagement from staff, despite several staff members passing by him. At 12:37 p.m. activity staff members were observed taking residents from the common area outside for ice cream. Resident #10 remained in the recliner chair by the nurses' station. -No staff members offered to take the resident outside, bring him ice cream or interact with him. At 1:08 p.m. an unidentified staff member asked Resident #10 if he needed anything. The resident did not respond and continued to nap. At 1:34 p.m. certified nurse aide (CNA) #4 patted the resident on the leg and called his name. CNA #4 did not engage further with the resident and did not offer the resident in activities. At 1:57 p.m. Resident #10 was observed sitting in a recliner. CNA #2 was standing nearby, but did not interact with the resident. At 3:13 p.m. Resident #10 was observed pulling on his pajamas and intermittently extending and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	flexing his legs. No staff members interacted with the resident to determine if he needed anything. On 3/25/26 at 1:45 p.m. Resident #10's room was observed for bedside objects to provide spiritual comfort to resident, according to the care plan. There were no spiritual objects present in the resident's room (see care plan below). C. Record review The activities care plan, initiated 6/20/24 and revised 8/18/25, documented that Resident #10 had an activity deficit that may be related to dementia. It documented that he was friendly, could socialize with others when given enough time to respond and could passively participate in activities but needed assistance to and from group activities. It documented that he would need encouragement to participate in at least two group activities or one-to-one activity visits of his choice each week, he would remain relaxed and comfortable during activities, and verbalize enjoyment. Interventions included assisting him to activities of his choice and inviting, encouraging, reminding and escorting him to activities consistent with his interests. The spiritual needs care plan, initiated 1/21/25 and revised 1/15/26, documented that Resident #10 was unable to express his beliefs or feelings of religion. It documented that the chaplain engaged with him daily at the nurses' station. Interventions included arranging the resident's room to have at the bedside objects that provided the resident spiritual comfort. Review of the resident's March 2026 activity attendance record revealed Resident #10 had not attended any activities, except on 3/26/26, and there were no refusals of activities documented. D. Staff interviews Activity assistant (AA) #1 was interviewed on 3/25/26 at 11:38 a.m. AA #1 said she had worked at the facility for five months. She said activities appropriate for Resident #10 included sensory activities, such as puzzles, listening to music, watching movies, and exercise such as walking. She said these activities were provided daily, five times per week. AA #1 said when Resident #10 was sitting at the nurses' station, she would encourage him in the morning and tell him what activities were planned for the day. She said if the resident did not attend group activities, he received one-to-one activities visits on Thursdays for approximately 25 to 30 minutes, which included walking and going outside. She said Resident #10 was offered activities daily and often declined, and said refusals were documented in the activities attendance record (see above attendance record). She said she was the only activities staff member working on Mondays and was responsible for activities on all three floors, which made it difficult to manage activities. She said she brought residents from the second and third floors to the first floor for participation. The activity director (AD) was interviewed on 3/26/26 at 12:30 p.m. The AD said activity staff were assigned by floor, with one coordinator leading activities on the first floor in the main activity room and another coordinator going to each floor to encourage resident participation. The AD said a resident council meeting was held monthly and resident suggestions were incorporated into activities. The AD said the chaplain was on military duty this month and activities staff were responsible for providing updates to residents regarding changes in activities. The AD said appropriate activities for Resident #10 included listening to music, aromatherapy, engaging with fidget items, conversation and walking with assistance from restorative services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no leisure activities were offered to any of the residents and there were no organized group activities offered during the observation period. At 1:35 p.m. CNA #6 sat in a chair in the TV room and started leg exercises. CNA #6 tried to engage all residents sitting in the TV room. Several residents started to participate. During a continuous observation of the facility's secured behavior and dementia care unit on 3/25/26, beginning at 9:37 a.m. and ending at 11:08 a.m., the following was observed: The activities calendar revealed that there was an event titled House of [NAME] scheduled to begin at 10:15 a.m. No staff were observed gathering residents to attend the event. Six residents were observed sitting in chairs in the TV room and sitting at the dining room tables of the common area. -However, the scheduled activity did not occur (see observation below). At 10:52 a.m. AA #1 came to the secure unit and told CNA #6 that after lunch she would take some residents outside. There were no leisure materials available on the tables, no leisure activities were offered to any of the residents and there were no organized group activities offered during the observation period. C. Record review Resident council meeting minutes were reviewed from October 2025 through February 2026. The October 2025 resident council meeting minutes revealed residents requested one-on-one activity visits, to go to the art museum and a Hanukkah party. The November 2025 resident council meeting minutes revealed residents requested games, such as Hangman, Jeopardy and Family Feud. The minutes additionally revealed a request from residents to hire weekend activity help. The February 2026 resident council meeting minutes revealed residents requested more assistance for bingo and group activities. The March 2026 activities calendar was reviewed. It revealed activities started at 8:30 a.m. with news and brews, rummy, or chess and checkers. Other activities included dress like a movie character, air hockey and bingo. Each day of the week had at least two activities scheduled. -However, group and individual activities were not observed occurring in the secure dementia care unit. D. Staff interviews CNA #6 was interviewed on 3/26/26 at 12:26 p.m. CNA #6 said the activities department was responsible for carrying out the activities in the secure unit. She said activities staff came and asked almost everyone to attend group activities located in the other units. CNA #6 said besides the activities scheduled on the calendar, residents could go outside, dance to music, color and tie dye shirts. CNA #6 said independent activities to keep residents engaged included watching TV, specifically the news and spending time with other residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities director (AD) was interviewed on 3/26/26 at 12:31 p.m. The AD said she started working at the facility in September 2025. She said she had three staff members plus herself in her department. She said she had two full-time activities staff members and one part-time staff member. She said her staff was scheduled to work either Sunday to Thursday or Tuesday to Saturday from 7:30 a.m. to 3:30 p.m or 8:00 a.m to 4:00 p.m. She said the evening activities were independent leisure activities because most residents were in bed and residents wanted activities to start early in the morning. The AD said she was fully staffed. The AD said she balanced activities for three units, including a secured unit carefully. She said when she had two staff schedules, she had one activities staff member leading the event while the other activities staff member was responsible for engaging with those residents not attending the activities. The AD said it was important for the support activities staff member to be on the third floor, the secure unit, because not a lot of the residents attended the group activities. The AD said the support activities staff member should go to the other floors to invite the residents. The AD said residents were informed about activities with the morning reminder and approximately 15 minutes to 30 minutes prior to the scheduled event, the activities staff should remind and gather the residents for the group activity. The AD said when residents sat idle in common areas, residents should watch television, read and play games, such as checkers, Uno and canasta. The AD said there were tools for residents to draw, complete crossword puzzles and do word searches. The AD said on 3/25/36 at 10:30 a.m. there was a House of [NAME] event and the support activities assistant should have invited residents on the secure unit to attend. The AD said she did not know why residents were not invited and she did not know why residents on the secured unit were not offered leisure activities.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional. Specifically, the facility failed to employ a qualified activities director in order to provide a program of activities for residents requiring activity and recreational support.Findings include: I. Professional referenceAccording to the National Certification Council of Activity Professionals (NCCAP) (2023), retrieved on 3/31/26 from www.nccap.org, an activity director must meet specific qualifications in education, certification and/or experience,The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which practicing; and,-Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or,-Has two (2) years of experience in a social or recreational program within the last 5 (five) years, one of which was full-time in a therapeutic activities program; or,-Is a qualified occupational therapist or occupational therapy assistant; or,-Has completed a training course approved by the state.An activity director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This includes completion of the activities component of the comprehensive assessment; contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident.II. Facility policy and procedure The Activities Director Qualifications policy and procedure, revised 3/24/26, was provided by the nursing home administrator (NHA) on 3/31/26 at 11:47 a.m. It read in pertinent part, The activities director, at a minimum, shall meet the following qualifications: licensed or registered by the state in which practicing and one or more of the following: eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the state.III. Record review The key personnel list was provided by the NHA on 3/23/26 at 3:34 p.m. Review of the staff list revealed an activity director (AD). -However, the NHA was unable to provide documentation that the AD had been enrolled in or had taken the required courses to be considered a qualified activity director. -Additionally, the NHA was unable to provide documentation that the facility had employed an activity consultant to provide oversight to the activities department.Activity records for Resident #19 revealed the residents' records were completed by the AD.Cross-reference F679 for lack of meaningful activity programs. IV. Staff interviews The AD was interviewed on 3/26/26 at 12:31 p.m. The AD said she started working at the facility in September 2025 and this was her first activities position. She said she had never worked in a nursing facility prior to working in the facility. She said she knew she had to take a course to become a qualified AD, but she had not started the course yet. She said she did not have an activities consultant to help her. She said she was the AD and she was responsible for planning the activities calendar for the facility's residents. The NHA was interviewed on 3/26/26 at 3:05 p.m. The NHA said the AD did not fit the requirements for an AD. The NHA said she thought as long as the AD was enrolled in a course, the facility met the requirements. The NHA said she would work to ensure the AD was supported by an activities consultant while taking the AD qualification course.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of three medication carts.Specifically, the facility failed to ensure residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened.Findings include:I. Facility policy and procedureThe Medication Storage policy, dated 3/24/26, was provided by the nursing home administrator (NHA) on 3/31/26 at 11:47 a.m. It read in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security.II. ObservationsOn 3/26/26 at 8:30 a.m. medication cart #2 on the second floor was observed with registered nurse (RN) #1. The following items were found:There was one umeclidinium-bromide (Incruse Ellipta) inhalation aerosol powder breath activated 62.5-25 micrograms (mcg) per actuation (mcg/act) inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #7.There were two bottles of polyethylene glycol-propylene glycol (Systane) 0.4 percent (%) ophthalmic (eye) drops stored in appropriately labeled medication boxes.-However, the individual medication bottles inside the boxes were not labelled with the resident's names or the dates the medications were opened for Resident #6 or Resident #7.There was one bottle of Biotene dry mouth moisturizing spray (artificial saliva) stored in an appropriately labeled medication box.-However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #7.There was one umeclidinium-vilanterol (Anoro Ellipta) inhalation aerosol powder breath activated 62.5-25 mcg/act inhaler stored in an appropriately labeled medication box. -However, the individual inhalation device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #25.On 3/26/26 at 8:40 a.m. medication cart #1 on the first floor was observed with licensed practical nurse (LPN) #4. The following items were found:There was one bottle of morphine sulfate 20 milligram per milliliter (mg/ml) oral solution stored in an appropriately labeled medication box.-However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #28.There was one vial of insulin lispro injection solution stored in an appropriately labeled medication box.-However, the individual medication vial inside the box was not labelled with the resident's name or the date the medication was opened for Resident #18.III. Staff interviewsRN #1 was interviewed on 3/26/26 at 8:30 a.m. RN #1 said medications should be labelled inside their respective boxes. She said it was important for the medications to be labelled inside the boxes in case the box was damaged.LPN #4 was interviewed on 3/26/26 at 8:40 a.m. LPN #4 said it was important for medications to be labelled inside their respective boxes because the medication inside could become separated from its box. He said an unlabelled medication without its box could potentially cause a medication error.The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 3/26/26 at 1:33 p.m. The DON said medications should be labelled inside their respective boxes. She said it was important for the medications to be labelled inside the boxes in case the box was damaged. The DON said a damaged medication box could become an infection control risk. The DON and the ADON said an unlabelled medication without its box could potentially cause a medication error because the nursing staff would not know who the medication belonged to.IV. Facility follow-upDuring their respective interviews on 3/26/26 at 8:30 a.m. and at 8:40 a.m. (see staff interviews above), RN #1 and LPN #4 used a Sharpie marker and labeled the identified items in their medication carts with the residents' names and the dates the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were opened.-However, the medications were not labeled in a manner consistent with professional standards until the concern was brought to the attention of the facility during the survey.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain emergency response carts and equipment in safe operating condition for three of five emergency (crash) carts.Specifically, the facility failed to:-Ensure staff completed daily equipment checks;-Ensure expired items were removed from the crash cart;-Ensure missing items were replaced on the crash cart; and,-Ensure staff had knowledge of which electrical outlets were connected to the emergency backup generator. Findings include:I. Professional referenceAccording to [NAME], [NAME], May 2022, retrieved on 3/30/26 from https://www.researchgate.net/publication/360555126_Crash_cart_preparedness_and_Failure_to_rescue_A_c crash cart is a mobile cabinet on wheels that contains equipment required for emergency cardio-pulmonary resuscitation. The carts are individualized and conveniently located throughout healthcare facilities for rapid access in the event of an emergency.A crash cart is typically located in the setting of an unexpected medical emergency. This could include severe allergic reaction, cardiac or respiratory arrest, and conditions with an unexpected sudden deterioration of vital signs. This would require equipment located on the crash cart which would be used by a credentialed life support provider. While crash carts vary depending on location, the fundamentals for the crash cart will contain similar equipment.Although the organization of requirements for a crash cart is not generic, there is a fundamental standard which provides effortless access to emergency medical equipment. Note that all these organizational points are checked, dated, and signed by the staff member who performed the daily routine inventory and inspection.Top shelf/drawer: the top section typically has the most frequently used equipment employed in a resuscitation event, such as power cords and personal protective equipment.Side or rear: the oxygen cylinder should be secure on the side of the cart, with a full oxygen pressure level; a suction apparatus/charging battery for the portable use; a sharps container should be secure on cart; and, a rigid plastic/fiberglass backboard for chest compressions.Recommended equipment and medications: organization and location specific.Recommended maintenance: check expiration dates on equipment and medications per organization policy and replace as required.Schedule inventory check. The purpose of a crash cart inventory is to organize a schedule of when to check for expiration dates of equipment and supplies.Check that equipment is operating as required in the event of an emergency. In addition to recording who performed the inventory checks, with dates, times, and signatures. An alarming situation for the healthcare personnel requiring a crash cart is to find unusable equipment or expired medications in an emergency. Ensuring that an up-to-date, accurate, and truthful inventory record can avoid potential patient safety situations such as absence of equipment, equipment failure, expired or missing medication, and empty oxygen cylinders.The patient safety risk incident failure to rescue is perpetrated by healthcare professionals when they do not check cart accurately. Failure to follow standard or policy for checking equipment compromises patient safety and creates potential to harm patients.II. Facility policy and procedureThe Emergency Crash Cart and Automated External Defibrillators (AEDs) policy, dated 3/24/26, was provided by the nursing home administrator (NHA) on 3/31/26 at 11:47 a.m. It read in pertinent part, It is the policy of this facility to ensure that the facility will maintain at least one emergency cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support. In addition, the facility will ensure that at least one AED (automated external defibrillator - a portable, life-saving device used to treat sudden cardiac arrest), if available, is for use in the case of cardiac emergencies. Equipment/supplies used from the emergency crash cart are noted and replaced promptly. The emergency crash cart is checked every 24 hours and after every use. Missing or expired items are replaced, when applicable. Nursing staff should be familiar with the contents located on and within the emergency crash cart.III. Observations and staff interviewsThree of the facility's crash carts were observed on 3/24/26. The observations revealed the following:At 1:06 p.m. there was no stethoscope, crash cart check-off log (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or oxygen tank key (to turn on the oxygen tank) present in the dining room crash cart on the first floor.At 1:11 p.m. there was no stethoscope, backboard or medical grade extension power cord present in the dining room crash cart on the second floor. The crash cart was not near an electrical outlet that indicated it was connected to the backup generator. There was a clipboard which held crash cart checklists that were dated July 2023.An unidentified staff member was interviewed on 3/24/26 at 1:15 p.m. The staff member said there was one crash cart located on floors one, two and three. He said the crash carts were located in the dining room.At 1:20 p.m. there was no backboard present in the crash cart on the third floor.Certified nurse aide (CNA) #3 was interviewed on 3/24/26 at 1:23 p.m. CNA #3 said if the backboard was missing from the crash cart, she did not know where it might be.The same three crash carts were observed on 3/25/26. The observations revealed the following:At 2:10 p.m. there was no oxygen tank key present in the dining room crash cart on the first floor. There was a March 2026 crash cart check-off log, which revealed the cart was audited on 3/24/26 (during the survey), and a stethoscope present.-However, the stethoscope and the crash cart check-off log were not present in the initial observation of the cart on 3/24/26 (see observation above).At 2:14 p.m. there was a backboard, March 2026 crash cart check-off log which revealed the cart was audited on 3/24/26 (during the survey), and a stethoscope present in the dining room crash cart on the second floor.-However, the backboard, the March 2026 crash cart check-off log and the stethoscope were not present in the initial observation of the cart on 3/24/26 (see observation above). -There was still no medical grade extension power cord present in the crash cart.Additionally, the following expired supplies were found in the dining room crash cart on the second floor:There were two 20-inch length non-conductive connection tubes (connects the suction machine to the Yankauer suction tip) with expiration dates of 5/1/22 and 6/1/22. There was a Yankauer suction tip (a firm, rigid catheter used to clear oral secretions) with an expiration date of 9/5/22.At 2:21 p.m. there was a backboard present in the third floor crash cart.-However, the backboard was not present in the initial observation of the cart on 3/24/26 (see observation above).The second floor dining room crash cart was observed with registered nurse (RN) #1 on 3/25/26 at 2:28 p.m. RN #1 said it was the night nurses' responsibility to complete the crash cart log and ensure the crash cart had all of the required emergency supplies on a nightly basis. She said the nurse who checked the crash cart should have attempted to turn on the suction machine to make sure it worked properly. RN #1 said it was important for the backboard to be included with the crash cart because a firm, flat surface was needed beneath the resident in order to provide effective chest compressions.RN #1 said she did not know which electrical outlets were connected to the backup generator. She said she knew where the nearest outlet to connect the suction machine to electrical power in the dining room was located.The second floor dining room crash cart was observed again with the director of nursing (DON) on 3/25/26 at 2:40 p.m. The observation revealed the following:There were two 20-inch length non-conductive connection tubes with expiration dates of 5/1/22 and 6/1/22. There was a Yankauer suction tip with an expiration date of 9/5/22.The DON said she did not know if the outlets in the second floor dining room were connected to the emergency backup generator. She said it was important to have a backboard on the crash cart in order to give effective compressions during cardiopulmonary resuscitation (CPR). The DON said the first day she worked at the facility was the first day of the recertification survey. She said one of the first things she identified that needed to be updated in the facility were the emergency crash carts. The DON said effective immediately, the crash carts needed to be checked nightly by the charge nurses to ensure the oxygen tanks and suction machines functioned properly, missing equipment was replaced and expired supplies were removed from the carts. She said she would not expect to see expired equipment on the crash carts if they were audited consistently.The assistant director of nursing (ADON) was interviewed on 3/26/26 at 3:05 p.m. The ADON said there were a total of five crash carts in the facility. She said there was one crash cart on the third floor and there were two crash carts located on the first and second floors, respectively.-However, staff members were not clear on the number or locations of the emergency (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	crash carts within the facility (see interview above).The DON was interviewed a second time on 3/25/26 at 3:57 p.m. The DON said she spoke to the maintenance director (MTD) and he was ordering a 15-foot electrical extension cord for the second floor dining room. She said she did not know if the electrical power cord the MTD ordered was a medical grade extension cord, but she said she would make sure it was. The DON said she contacted the facility's fire safety contractor to get an estimated date for project completion to make sure there were electrical outlets that were connected to the backup generator.The NHA provided a receipt for the 15-foot medical grade electrical extension cord on 3/25/26 at 7:54 p.m. She also provided communication from the electrical contractor, which said the contractor would be at the facility on 3/27/26 for identification and labelling of the facility's emergency electrical outlets.The DON was interviewed a third time on 3/26/26 at 9:50 a.m. The DON said the MTD notified her that the medical grade electrical extension cord would be delivered on 3/27/26. She said in the meantime, a heavy-duty extension cord had been placed in the second floor dining room crash cart. The DON said the MTD would exchange the heavy-duty extension cord for the medical grade extension cord when it arrived.-However, the crash carts were not maintained in safe operating condition until the concern was brought to the attention of the facility during the survey.

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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 record review and interviews, the facility failed to ensure two (#28 and #55) of five residents were free from chemical restraints out of 32 sample residents.Specifically, the facility failed to: -Ensure Resident #28's representative was informed of the facility's decision to implement a gradual dose reduction (GDR) after the pharmacist and the physician recommended a GDR of the resident's Zyprexa (antipsychotic medication);-Ensure Resident #55's antipsychotic medication was appropriately monitored and reviewed by the interdisciplinary team (IDT); and, -Ensure Resident #55's care plan included resident-specific non-pharamacological care approaches for the resident's behaviors.Findings include: I. Facility policy and procedure The Gradual Dose Reduction (GDR) of Psychotropic Drugs policy, revised on [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 11:47 a.m. It read in pertinent part, Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. Gradual Dose Reduction refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Opportunities during the care process to consider whether medications should be continued, reduced, discontinued, or otherwise modified included during the monthly medication regimen review by the pharmacist, when the physician or prescribing practitioner evaluates the resident's progress, and during the quarterly MDS (minimum data set) assessment review by the interdisciplinary team (IDT). II. Failed to ensure Resident #28's representative was informed of the facility's decision to implement a gradual dose reduction (GDR) after the pharmacist and the physician recommended a GDR of the resident's Zyprexa (antipsychotic medication) A. Resident status Resident #28, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included dementia unspecified severity with other behavioral disturbance, bipolar disorder, and weakness. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. She was dependent on staff for assistance with toileting, bathing and dressing. The MDS assessment indicated the resident did not exhibit verbal or physical behavior toward others, reject care or wander. B. Resident #28's representative interview Resident #28's representative was interviewed on [DATE] at 9:56 a.m. Resident #28 said the facility did not discuss decreasing the dose of the resident's antipsychotic medication, Zyprexa, during the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care conference on [DATE]. Resident #28's representative was interviewed a second time on [DATE] at 2:22 p.m. The representative said if the pharmacist and the physician recommended a dose reduction of the resident's medication, she would agree to decrease the dose. She said she would wait for the facility to contact her. She said she often visited Resident #28 and the resident was very sleepy. She said the last time she visited her was on [DATE], and the resident was very sleepy and it could have been due to her Zyprexa. C. Observations On [DATE] at 8:48 a.m. Resident #28 was sleeping in her bed in her room. On [DATE] at 11:02 a.m. Resident #28 was sleeping in her bed in her room. On [DATE] at 12:23 p.m. Resident #28 was sleeping in her bed in her room. D. Record review The [DATE] CPO revealed the following physician's orders: Olanzapine (Zyprexa) oral tablet 10 milligrams (mg) by mouth in the evening for dementia, ordered [DATE]. Review of the [DATE] consultant pharmacist recommendation revealed the pharmacist recommended a GDR of olanzapine from 10 mg to 7.5 mg for Resident #28. The physician agreed with the recommendation on [DATE] and documented for staff to confirm the GDR with the resident's representative prior to implementation. Review of the [DATE] physician progress note documented the facility consultant pharmacist requested a Zyprexa (olanzapine) GDR for Resident #28. The physician documented Resident #28 had no recent behaviors on the current medication regimen and staff were to reach out to the resident's representative to discuss the GDR. Review of the [DATE] and [DATE] physician progress notes revealed the resident remained on Zyprexa (olanzapine) with no recent behaviors and staff were to reach out to the Resident #28's representative to confirm the changes prior to implementing the GDR of the medication. Review of the [DATE] care conference revealed Resident #28's medication was reviewed and no changes were identified. -However, the resident's representative said the GDR of the resident's olanzapine medication was not discussed with her in the care conference (see resident's representative interview above). -There was no documentation in Resident #28's electronic medical record (EMR) to indicate the resident's representatives were informed of the olanzapine GDR. -A second review of Resident #28's [DATE] CPO on [DATE] revealed the physician's orders were updated to decrease olanzapine to 7.5 mg by mouth in the evening, ordered [DATE] (over a month (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the pharmacist and the physician recommended the GDR and directed staff to speak with the resident's representative about it). E. Staff interviews The social services director (SSD) was interviewed on [DATE] at 10:02 a.m. The SSD said she had worked at the facility for three years. She said during the care conference for Resident #28 on [DATE], both of the resident's representatives were present and the team should have reviewed the resident's medications. She said she reviewed the Medical Orders for Scope of Treatment (MOST) form and the director of nursing (DON) or the assistant director of nursing (ADON) was responsible for communicating medication changes and dose reductions to the representatives. She said the issue with not discussing the medication reduction with the representatives was that the resident would have benefited from a dose reduction and she said she would speak with the ADON regarding this. The ADON was interviewed on [DATE] at 10:09 a.m. The ADON said nursing staff was responsible for sending the pharmacist's recommendation for a GDR to the physician and once the physician agreed, the orders for the dose reduction were implemented. She said nursing staff was supposed to contact the resident's representative regarding Resident #28's GDR of olanzapine so they could make a decision. She said the previous DON should have discussed the GDR during the care conference on [DATE]. She said she could not participate in the care conference on [DATE]. She said it was important the medication be reduced because the physician had determined the dose should be decreased and it could be dangerous for the resident if she was not receiving the right dose. The DON was interviewed on [DATE] at 10:20 a.m. The DON said she started working at the facility on [DATE]. She said the facility tracked dose reductions through pharmacy recommendations, implementation and follow-ups with the physician. She said the pharmacy recommendation for reduction of Resident #28's olanzapine was not followed through on and staff education would be provided to ensure recommendations were tracked and followed through. She said after the pharmacist recommended a dose reduction, the resident's family needed to be notified. She said the facility would do more to collaborate to ensure family notification about GDRs occurred. She said she would call Resident #28's representative to determine what decision would be made about reducing the resident's olanzapine. Certified nurse aide (CNA) #1 was interviewed on [DATE] at 11:09 a.m. CNA #1 said Resident #28 had no behaviors except during care when being changed. She said the behaviors did not occur frequently and happened once in a while. She said the resident became agitated, threw her arms and calmed down with reassurance. She said she would report the behavior to the nurse and the nurse would document it. III. Failed to ensure Resident #55's antipsychotic medication was appropriately monitored and reviewed by the IDT and the resident's care plan included resident-specific non-pharamacological care approaches for the resident's behaviors A. Resident status Resident #55, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included Alzheimer's disease, dementia with mood disturbances, hypertensive heart disease (heart disease caused by long term high blood pressure), major depressive disorder, insomnia, and post traumatic stress disorder. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] MDS assessment revealed the resident was cognitively impaired with a BIMS of nine out of 15. He used a walker. He was independent with eating and he required supervision with oral hygiene. He required substantial assistance with toileting and showering. He required moderate assistance with personal hygiene. The resident did not exhibit verbal or physical behavioral symptoms toward others, reject care or wandered during the assessment look-back period. The MDS assessment revealed the resident was depressed and had post-traumatic stress disorder. The MDS assessment revealed the resident was prescribed an antidepressant medication. B. Record review The wandering and elopement care plan, initiated [DATE] and revised [DATE], revealed Resident #55's family disclosed he had a history of leaving familiar settings. Interventions included clearly identifying Resident #55's room, engaging Resident #55 in purposeful activities and scheduling time for regular walks and appropriate activities. The cognition care plan, initiated [DATE] and revised [DATE], revealed Resident #55 was at risk for altered cognition due to dementia with agitation that caused poor safety awareness. Interventions included participating in daily care and decision making as able, contacting family for decision-making assistance and engaging the resident in frequent conversations using reminiscence, life review and validation. The mood care plan, initiated and revised [DATE], revealed Resident #55 liked to talk about his life and would tear up talking about his spouse. Interventions included family support and involvement and providing comfort. The [DATE] CPO revealed the following physician's orders: Sertaline (an antidepressant medication) 100 mg. Take one tablet by mouth one time a day for dementia with mood disturbance, post traumatic stress disorder and depression, ordered [DATE]. Trazodone (an antidepressant medication) 100 mg. Take one tablet by mouth at bedtime for insomnia, ordered [DATE]. Seroquel (an antipsychotic medication) 12.5 mg. Take one tablet by mouth for dementia with behaviors and agitation. Try to give as close to 3:00 p.m. as possible to prevent sundowning symptoms in the late afternoon, ordered [DATE] and discontinued [DATE]. Risperidone (an antipsychotic medication) 0.5 mg. Take one tablet by mouth at bedtime for dementia with behaviors, ordered [DATE] and discontinued [DATE]. Seroquel 12.5 mg. Take one tablet by mouth two times a day for dementia with behaviors and agitation, ordered [DATE]. Monitor hours of sleep related to trazodone use, ordered [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alert for and notify the physician if any of the following occur: increased fatigue, sleep disturbance, anxiety, restlessness, nausea, headache, dizziness, tardive dyskinesia and suicidal ideations. If yes, list and notify the physician, twice a day for antidepressant medication, ordered [DATE]. Monitor the resident for increased Sertaline two times a day for depression, ordered [DATE]. Monitor and chart on the resident for reactions to starting on Seroquel two times a day for dementia with behaviors and agitation, ordered [DATE] and discontinued [DATE]. Monitor and chart on the resident for reactions to starting Risperdal two times a day related to dementia with mood disturbances, ordered [DATE] and discontinued [DATE]. Monitor and on chart the resident for behaviors for 14 days due to a medication change from Risperdal to Seroquel two times a day for behaviors, ordered [DATE] (during the survey). The [DATE] social services note revealed Resident #55's mood, psychosocial well-being and psychoactive medication were reviewed by the physician, the DON and social services. -However, there was no documentation of what specifically was reviewed and what decisions were made. The [DATE] consultant pharmacist's recommendation to the physician regarding Resident #55's sertraline medication revealed practice guidelines for major depression for sertraline in primary care recommended continuing the same dose for four to nine months following the acute phase. A trial dose reduction might be reasonable. The resident had been using 75 mg four times a day since [DATE]. If the medication therapy was required to prevent future depressive episodes, the pharmacist requested for the physician to document that in the progress notes. In response to the pharmacist's recommendations, the physician checked the box on the form to continue Resident #55's antidepressant therapy and a dose reduction was contraindicated. The physician documented the medication could be discussed at the psychopharmacology meeting as the physician was not sure when the resident's previous gradual dose reductions were. -However, the physician signed the form on [DATE], two months after the pharmacist's recommendation for a GDR of Resident #55's sertraline medication. The [DATE] social services note revealed Resident #55's mood, psychosocial well-being and psychoactive medication reviewed by the physician, the DON and social services. -However, there was no documentation of what was specifically reviewed and what decisions were made. The [DATE] physician's note revealed Resident #55 went to the emergency room on [DATE] for agitation and threats towards staff members. A behavioral health services referral was placed on [DATE], though the physician documented there were no notes from the behavioral health services provider in the resident's EMR The resident's sertraline was increased from 75 mg daily to 100 mg daily to try and help with some behaviors, but nursing staff had stated the resident's behavior and sundowning were consistently getting worse and a medication change did not make a difference. The physician called behavior health services to discuss a couple of options. Behavioral health services (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreed the resident's symptoms seemed most consistent with sundowning behaviors and recommended a very low dose of Seroquel to start as the resident had never had the medication before. The physician discussed with nursing to start the medication while the facility's behavioral health services team established care with the resident. The [DATE] behavior note, documented at 3:50 p.m., revealed Resident #55 started yelling and screaming he wanted to go home. The resident went to the phone room and called 911. The nurse was able to talk to the operator and explained the situation to her. The resident went to his room, closed the door and started yelling for help to call the police. The resident went to the TV room and started pushing furniture and threw anything he could lay his hands on. He calmed down at 4:30 p.m. The [DATE] psychiatric evaluation note revealed staff reported Resident #55 was difficult to redirect, was exit-seeking and verbally or physically aggressive when staff tried to redirect him. He was started on a low dose of Seroquel for increased behaviors and aggression in the afternoon. The [DATE] nurse note revealed Resident #55 was crying and told the nurse his wife died. He started yelling for help to go to the hospital or call the police to take him home. He went to the elevator and blocked the entrance, saying if 911 or the police was not called, he would not move out of the way. The DON was notified. She came with another CNA and an admissions staff member, but they were unable to redirect the resident. The resident refused to talk to his family. He tried to put himself on the floor but two staff members held him to ease him to the floor. After a while, he was helped up and was redirected to sit in the TV room. The [DATE] behavior note revealed Resident #55 was observed between 1:00 p.m. to 3:30 p.m., very agitated and exit-seeking. The resident stood in front of the big elevator for about 30 minutes. The resident pounded on the wall yelling and screaming, looking for his wife and son. He could not be redirected. The [DATE] psychiatric note revealed the resident continued to present with delusions of being in a hotel, irritability and was difficult to redirect. Recommendations included titrating his risperidone medication as needed, as titration had been shown to have some beneficial efficacy with dementia behaviors. The reason for the psychiatrist's visit was the resident's agitation. The resident was evaluated in the hallway standing by the nurse's station. He was irritable and minimally cooperative throughout the session. He presented with a dysphoric (profound sense of unease, unhappiness and dissatisfaction) mood and restricted affect. He appeared to have a current delusion that he was waiting for the police to arrive because they would not let him into his hotel room. The psychiatrist attempted to reorient the resident to the situation with no benefit. The resident said he was waiting for his wife because they needed to go to the car show. The psychiatrist attempted to redirect the resident to assessment questions with no benefit. The resident appeared fixated on the notion his wife was still alive and he was meant to be at a car show. The [DATE] behavior note revealed Resident #55 was very agitated between 1:00 p.m. to 4:00 p.m. and was looking for his son and wife. The resident wandered, looking for a place to exit the unit. He looked through the windows to find his car in the parking lot so he could drive away. The resident was found at the nurses' station two times using the phone and tried to pull the fire alarm. At 4:00 p.m. he calmed down after a shower. The [DATE] morning behavior note revealed Resident #55 called 911 saying he wanted to get out of the facility. The police called and were told the resident often did this, but the resident's (continued on next page)

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Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative wanted him to stay at the facility. After a number of attempts calling 911, the resident went to his bedroom. The [DATE] behavior note revealed Resident #55 continued on monitoring for Risperdal use with no adverse reactions noted. The resident was observed between 6:30 a.m. and 7:00 a.m. yelling and screaming for help but staff could not tell what he wanted and the resident was not redirectable. After dinner, the resident asked for a phone to call his wife to come pick him up. He yelled and it took 30 minutes to redirect him. The [DATE] afternoon behavior note revealed after dinner, the resident went to his room put on a jacket and returned to the dining room and started to shout that he wanted to call his wife so he could go home. The resident was not redirectable at that time and the floor nurse came to assist him. The [DATE] nurse note revealed Resident #55 was agitated with confusion around 8:00 p.m. The nurse informed the house supervisor who came to intervene but was unsuccessful. The supervisor called the resident's representative who spoke with the resident at length with no impact. The supervisor called the ADON who suggested giving the resident an additional dose of risperidone 0.5 mg to control the resident's behavior, but the offer was rejected by the resident. The [DATE] nurse note revealed the resident was agitated and reported to staff he did not like to stay here and wanted to go out. Staff tried to redirect the resident but the resident was more agitated and activated the emergency door alarm five times. Staff provided one-on-one care but the resident tried to hit staff with his walker and tried to break the facility window with his oxygen tank. Staff tried to notify the physician for more than 45 minutes but were unsuccessful. Staff called the medical director for a physician's order to send the resident to the hospital for further evaluation. The [DATE] nurse note revealed Resident #55 returned from the emergency room and he was in a confused state and said where is my wife and why am I here. Staff redirected the resident multiple times. The [DATE] behavior note revealed Resident #55 was on monitoring for medication changes from Risperdal to Seroquel with behaviors noted between 4:00 p.m. to 5:20 p.m. The resident stated the building belonged to him and he wanted everyone out of the building, especially two residents he pointed to. He was very difficult to redirect. The SSD came and took the resident to her office for about 15 minutes and brought him back. The resident was quiet for about 10 minutes and then started yelling for everyone to get out of the building. The resident went to his room and the nurse talked to him for about five minutes and brought him back to the TV room. He saw the residents in the TV room watching TV and he turned the TV off and went back to his room. -A review of Resident #55's EMR revealed there was no documentation of what specific interventions were offered and if the interventions were effective when the resident was exhibiting behaviors. -A review of Resident #55's EMR revealed there were no person-centered non-pharmacological interventions documented for dementia, depression and insomnia. -A review of Resident #55's EMR revealed there was no documentation on what behaviors the facility was specifically monitoring for Resident #55 and what interventions were identified to help Resident #55 if he exhibited any behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of Resident #55's EMR revealed there was no documentation to indicate the IDT reviewed the resident's use of sertraline to determine if the continued use of the medication was justified and if a GDR of the medication was indicated. C. Staff interviews CNA #6 was interviewed on [DATE] at 12:15 p.m. CNA #6 said she was familiar with Resident #55. She said his behaviors escalated when he could not talk to his family. CNA #6 said his family took his personal phone away because he called them every two minutes. She said Resident #55's wife was dead but he did not remember and wanted to talk to her. CNA #6 said checkers, eating ice cream and drinking coffee helped de-escalate his behaviors. She said another way to help de-escalate his behavior was when she talked to him about his plans for tomorrow. She said talking about tomorrow helped relax Resident #55. Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 10:35 a.m. LPN #2 said he knew what behaviors to monitor based on what the resident needed. He said he knew what de-escalated a resident's behavior by talking to the resident to learn what caused their current behavior. He said it was important to remember most residents would not remember what he said, so it was important to not say he already answered the resident's question. LPN #2 said he did not document every behavior, but if it was a behavior out of the ordinary, such as an aggressive behavior, he wrote a progress note. LPN #2 said he was familiar with Resident #55. He said he was one of the residents who did not remember what he said and Resident #55 asked about his son. He said he would meet the resident where he was to help not escalate his behaviors. The DON was interviewed on [DATE] at 3:50 p.m. She said the IDT was responsible for determining what resident behaviors needed to be monitored. She said it started before the resident was admitted to the facility by reviewing the referral admission packet and reviewing clinical notes, including the clinical diagnoses and behavior notes. The DON said she reviewed the physician's orders to see if there were psychotropic medications or if there were orders to monitor behaviors. The DON said interventions were determined by monitoring the resident when they were first admitted to the facility or first started a psychotropic medication. She said from there, the IDT care planned what behaviors were monitored and what interventions to use. The DON said residents who were on psychotropic medications were reviewed by the IDT in the first month they started the medication, quarterly and as needed. She said the IDT reviewed how long the resident was on the medication, what behaviors the resident had, their sleeping patterns, their nutrition status, if a GDR was appropriate, and if they had signs of tardive dyskinesia (a medication-induced movement disorder characterized by involuntary repetitive movements most often in the face). The DON said non-pharmacological interventions should be offered before a resident started any new medication. The DON said interventions should be documented in the care plan. The DON said she was new and was not familiar with Resident #55.

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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 received services and assistance to prevent a reduction in range of motion for two (#6 and #10) of four residents reviewed for range of motion out of 32 sample residents. Specifically, the facility failed to: -Ensure preventative measures were put into place for Resident #6's bilateral hand contractures; and, -Ensure preventative measures were followed for Resident #10 to prevent further body misalignment.Findings include: I. Facility policy and procedure The Restorative Care policy and procedure, revised 3/24/26, was provided by the nursing home administrator (NHA) on 3/31/26 at 11:47 a.m. It read in pertinent part, Residents will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services include passive or active range of motion, splint or brace assistance, and bed mobility training and skill practice. Potential candidates for restorative nursing services may be identified through physical assessments, MDS (minimum data set) assessments, specialized rehabilitation assessments, or in-house referrals prompted by unusual occurrences or events. The restorative nurse is responsible for maintaining a current list of residents requiring restorative nursing services and ensuring that all elements of each resident's program are implemented. Each resident's restorative nursing plan will include the problem, need, or strength the restorative tasks are intended to address; the type of activities to be performed; the frequency and duration of activities; and measurable goals with target dates. The discharging therapist, restorative nurse, or designated licensed nurse will communicate the provisions of the resident's plan to the appropriate restorative aide and provide any necessary training to carry it out. Restorative aides will implement the plan for the designated length of time, performing the assigned activities and documenting them on the Restorative Aide Documentation Form or another facility-designated form. The restorative nurse, or designated licensed nurse, will provide oversight of the restorative aide's activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly, documenting the outcomes accordingly. II. Failed to ensure preventative measures were put into place for Resident #6's bilateral hand contractures A. Resident status Resident #6, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included paranoid schizophrenia, dementia with agitation, depression, delusional disorders and catatonic disorder. The 3/26/26 MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. She was dependent on others for oral hygiene, toileting, showering and upper and lower dressing. The MDS assessment revealed the resident had received no physical or occupational therapy services during the assessment look-back period. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident #6's representative interview Resident #6's representative was interviewed on 3/24/26 at 2:04 p.m. The representative said he was frustrated with the facility because Resident #6 had started to have contractures (the permanent, often painful shortening of muscles, tendons, or skin, causing rigid joint stiffness and limited motion) in both hands in November 2025. He said the contractures were due to a muscle spasm related to the medications she took. He said he had asked the facility if they could place a brace or even a towel in between her hands to prevent the contractures from getting worse. He said the facility said she could not use a brace or towel because they were concerned the resident might swallow the supplies. The representative said he thought the facility gave up on Resident #6's contractures because in order to put a brace or a towel in between her fingers and palm, it needed to be done slowly because the contractures caused her so much pain. He said no one had talked to him or another resident representative about what the facility was doing to prevent the resident's contractures from getting worse. He said it had been a nightmare for him and the other resident representatives. C. Resident observation On 3/24/26 at 1:44 p.m. Resident #6 was lying in her bed in her room. She was unable to answer any questions. Both of the resident's right and left hands were contracted. Her left fingers were almost touching the palm of her left hand with about one inch of space between her fingers and her palm. Her fingers on her right hand were touching the palm of her hand. The resident was not wearing hand splints on either hand. On 3/25/26 at 9:36 a.m. Resident #6 was lying in her bed in her room. Resident #6 did not have a brace or splint on either hand. D. Record review The pain care plan, initiated 4/8/25 and revised 6/3/25, revealed Resident #6 had the potential for pain related to a history of global decline in function, impaired mobility, contractures and osteoarthritis. Interventions included non-medication pain relief techniques and implementing relaxation techniques to assist with pain control. -The care plan failed to indicate if passive range of motion was being utilized as an intervention for Resident #6's contracted hands. -A review of Resident #6's Kardex (an abbreviated care plan) and March 2026 CPO failed to indicate if the resident was receiving passive range of motion for her contracted hands. The 11/24/25 occupational therapy (OT) discharge summary indicated the OT's recommendations included passive range of motion with the resident's upper and lower extremities. -However, there was no documentation in Resident #6's electronic medical record (EMR) to indicate that passive range of motion was offered was provided to the resident from 11/24/25 to 3/26/26. E. Staff interviews Certified nurse aide (CNA) #7 and licensed practical nurse (LPN) #3 were interviewed together on (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a pillow or cushion to support his neck. Two unidentified staff members were present at the nurses' station but did not provide the resident with any support for his neck. On 3/23/26 at 4:09 p.m. Resident #10 was by the nurses' station in the recliner chair in a fully extended position. The resident had periods of being asleep and awake and he was heard saying something that could not be understood while his eyes remained closed. His neck remained tilted to the left without a pillow or cushion to support his neck. On 3/24/26 at 8:48 a.m. Resident #10 was sitting in a reclining chair by the nurses' station with the recliner fully extended in a reclined position. His head was tilted to the left side and no staff members provided assistance with repositioning the resident's neck. During a continuous observation on 3/24/26, beginning at 12:23 p.m. and ending at 3:25 p.m., the following was observed: At 12:23 p.m. Resident #10 was observed sitting in a recliner by the nurses' station with the recliner fully extended in a reclined position. -The resident's neck was not supported with a pillow or cushion. At 1:08 p.m. an unidentified staff member asked the resident if he needed anything. The resident did not respond and continued to nap. His neck remained tilted to the left without a pillow or cushion to support his neck. -However, the unidentified staff member did not offer to provide the resident with support for his neck. At 1:34 p.m. CNA #4 patted Resident #10 on the leg and called his name but did not attempt to reposition the resident's neck or provide a pillow for support. At 1:57 p.m. Resident #10 was observed sitting in a recliner with his head significantly tilted to the left, resting close to his shoulder, and he was unable to maintain an upright head position. CNA #2 was standing nearby and did not provide repositioning or offer a pillow for support. At 3:16 p.m. CNA #2 and another unidentified staff member assisted Resident #10 to stand using a gait belt and ambulated with him down the hall. The resident was unable to maintain his neck in an upright position when ambulating. The CNAs provided care for the resident and returned the resident to the recliner at 3:24 p.m. The resident's neck continued to be tilted to the left. -CNA #2 and the unidentified staff member did not provide a pillow to support the resident's neck once they returned him to the recliner. On 3/25/26 at 9:44 a.m. Resident #10 was sitting in a recliner by the nurses' station with a small pillow in place to support his neck. C. Record review The pressure ulcer care plan, initiated 1/15/24, documented Resident #10 had a potential for pressure ulcer development related to severe dementia and incontinence. Pertinent interventions included (continued on next page)

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