STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065217	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canon Lodge Care Center	905 Harding Ave Canon City, CO 81212

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and to help prevent the development of transmission of infectious disease.Specifically the facility failed to:-Ensure housekeeping staff followed appropriate hand hygiene processes when cleaning resident rooms;-Ensure housekeeping staff changed the mop head in a multiple resident room; and,-Ensure enhanced barrier precautions (EBP) were followed. Findings include: I. Housekeeping failures A. Facility policy and procedure The Daily Room Cleaning policy, revised 2/24/22, was provided by the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It read in pertinent part, The cleanliness of each resident's room is maintained on a daily basis by the housekeeping staff to provide a fresh, clean and sanitary environment and reduce the potential for nosocomial infections. B. Observations During a continuous observation on 8/13/25, beginning at 9:01 a.m. and ending at 9:53 a.m., the following was observed: At 9:02 a.m. the housekeeping director (HKD) used hand sanitizer and donned (put on) gloves. The HKD entered a single occupancy room. The HKD sprayed a cloth with Virex II 256, wiped the sink and wiped the area around the sink. She placed the dirty cloth in the bag on the cart and grabbed a new cloth, without changing gloves or performing hand hygiene. She cleaned the surfaces of the bedroom furniture, bed frames, lights, shelves, tray table, call lights and remotes. She cleaned the window sill and blinds. She exited the room and grabbed the toilet brush and comet, without changing gloves or performing hand hygiene. She scrubbed the inside of the toilet and then flushed the toilet when done. The HKD mopped the room and the bathroom with two separate mop heads, without performing hand hygiene or changing her gloves after touching the dirty one and before touching the clean one. When she was finished cleaning the room at 9:16 a.m., she removed her gloves and performed hand hygiene. -The HKD failed to change her gloves between cleaning the room and bathroom. At 9:16 a.m. the HKD donned gloves and entered room [ROOM NUMBER], where three residents resided in. The HKD sprayed her clean cloth with Virex II 256, wiped the sink and wiped the area around the sink. She placed the dirty cloth in the bag on the cart and grabbed a new cloth, without changing gloves or performing hand hygiene. She cleaned the surfaces of the bedroom furniture, bed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	frames, lights, shelves, tray table, call lights and remotes. She cleaned the window sill and blinds. She disposed of the dirty cloths and then took out two mop heads from the bucket and placed them on the floor. She did not perform hand hygiene or change her gloves after touching the dirty cloths and before touching the clean mop heads. She mopped the whole room using one mop head. She used the second mop head to clean the bathroom. At 9:53 a.m. the HKD exited room [ROOM NUMBER] and removed her gloves and sanitized her hands. -The HKD failed to use new mop heads for each resident area and failed to change gloves after touching a contaminated item and before touching a clean item. C. Staff interviews The HKD was interviewed on 8/13/25 at 9:55 a.m. The HKD said she used the bleach or Virex II 256 for the mop heads. The HKD said the blue cloths were for cleaning the rooms and the yellow cloths were used for the bathrooms. The HKD said the mop heads were set up the same way. The maintenance director (MTD) was interviewed on 8/13/25 at 10:13 a.m. The MTD said the housekeepers were trained upon hire through orientation and ongoing training was completed on a regular basis. The MTD said after removing gloves the staff member should always perform hand hygiene before putting clean gloves on. The MTD said the housekeepers should change their gloves after cleaning the room and after cleaning the bathroom. He said he would immediately provide education to the housekeeping staff on the correct room cleaning procedure and hand hygiene. II. EBP failures A. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 8/20/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status. B. Facility policy and procedure The Enhanced Barrier Precautions policy, revised 4/22/25, was provided by the NHA on 8/14/25 at 1:15 p.m. It read in pertinent part, The facility should use enhanced barrier precautions (EBP) as an additional multidrug-resistant organisms (MDRO) mitigation strategy for residents that meet the following criteria, during high-contact resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP are indicated for residents with indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheostomies. EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contract resident care activities. High contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, medical device care or use and wound care. Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross transmission. C. Observations On 8/11/25 at 2:41 p.m. Resident #2's room was observed to have a sign on the door identifying the room required EBP. There was a container of PPE to the right of the door. Resident #2 was sitting in his wheelchair. Two unidentified staff members entered Resident #2's room with the Hoyer lift (mechanical lift). The two unidentified staff members entered the room without donning PPE. When the two unidentified staff members exited the resident's room they used hand sanitizer. Resident #2 was observed lying down in his bed. D. Resident interview Resident #2 was interviewed on 8/12/25 at 3:40 p.m. Resident #2 said he had a catheter. He said when the staff transferred him from his wheelchair to his bed, the staff did not put on gloves or a gown on. E. Staff interviews The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 8/13/25 at 5:12 p.m. The IP said the facility currently had residents who required [NAME]. The IP said she was responsible for ensuring there was an isolation cart with PPE for the staff to use and a sign in place to notify the staff that the resident was on EBP She said staff should be wearing PPE when transferring a resident who was on enhanced barrier precautions. She said she would provide education to staff on when to use PPE. F. Additional observations On 8/11/25 CNA #1 entered Resident #4's room. There was a PPE container outside of the resident's room. CNA #1 applied gloves and pulled the curtain. She provided foley catheter care to Resident #4. CNA #1 then opened the curtain, while wearing the same gloves used to drain the foley bag. She removed her gloves and performed hand hygiene with an alcohol based hand rub upon exiting the resident's room. -CNA #1 failed to put on a gown prior to providing care to a resident who was on EBP. E. Additional staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 was interviewed on 8/13/25 at 9:36 a.m. She said the staff should wear PPE when performing any catheter care to a resident who has a catheter. CNA #1 said PPE should be worn even when emptying the bag to protect from splashing. CNA #1 said she was not sure why she did not wear a gown when emptying the resident's catheter. RN #1 was interviewed on 8/13/25 at 10:47 a.m. She said staff were to apply PPE when providing care to a resident with a catheter or open area to the body. RN #1 said Resident #4 was on EBP and staff should be applying gloves and gowns while providing care. The DON was interviewed on 8/13/25 at 4:17 p.m. She said the staff needed to wear PPE when emptying catheter bags because they were to be on EBP. The DON said there should be a sign on the door indicating what type of precautions were to be taken when proving certain cares, she was unaware there was no sign on the door. The DON said they had a new infection preventionist starting next week. The DON said wearing PPE was important to help prevent infections.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure consent was obtained for the use of psychotropic medication for one (#26) of five residents reviewed for unnecessary medications out of 28 sample residents. Specifically, the facility failed to ensure Resident #26's responsible party was informed of an increase to psychotropic medications. Findings include: I. Facility policy and procedureThe Resident Rights facility policy and procedure, revised November 2016, was provided by the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It revealed in pertinent part, A facility must immediately inform the resident; consult with the resident`s physician; and notify, consistent with his or her authority, the resident representative(s) when there is a need to alter treatment.II. Resident #26A. Resident statusResident #26, age [AGE], was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnosis included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, depression and cognitive communication deficit. According to the 4/17/25 minimum data set (MDS) assessment the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. B. Record reviewA review of Resident #26's electronic medical record (EMR) revealed consent forms were signed by the resident's representative for the following medications:-Seroquel (antipsychotic) 50 milligrams (mg), signed on 4/21/25;-Escitalopram Oxalate (antidepressant), signed on 5/31/25; and,-Haloperidol (antipsychotic) 1 mg, signed on 4/17/25.Review of the August 2025 CPO revealed the following medication dosage changes:-Seroquel oral tablet was increased to 25 mg three times a day on 7/8/25; -Escitalopram Oxalate tablet was increased to10 mg a day on 7/9/25; and-Haldol 2 mg was decreased to 0.5 mg two times a day on 7/10/25.The 7/8/25 psychotropic medication review documented the interdisciplinary team (IDT) determined to increase the dosage of Seroquel, Lexapro and to decrease Haldol.The July 2025 medication administration record (MAR) documented Resident #26 was administered the increased doses of Seroquel starting on 7/8/25, Lexapro starting on 7/9/25 and decreased dose of Haldol on 7/10/25.A review of the resident's EMR did not reveal documentation Resident #26's responsible party had been notified of the changes to the psychotropic medications until 7/23/25 (15 days after the Seroquel was increased and 14 days after the Lexapro was increased) during the care conference when all medications were documented as reviewed. III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 8/13/25 at 2:29 p.m. LPN #1 said it was the nurses responsibility to notify the resident and/or family with any medication changes. She said the nurse should call the resident`s power of attorney (POA) or designated contact to obtain a verbal and/or written consent. She said the call should be documented in the progress notes. LPN #1 said Resident #26 was enrolled in hospice care during the psychotropic medication increases. She said there was confusion at that time whether the facility or the hospice should have notified the family.The director of nursing (DON) was interviewed on 8/13/25 at 3:04 p.m. The DON said she notified Resident #26`s POA verbally regarding the psychotropic medication increase, but did not document it in the resident's medical record. She said the facility did not have the resident's POA sign a consent form, which was their process.

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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 record review and interviews, the facility failed to ensure one (#8) of three residents reviewed for abuse out of 28 sample residents were free from abuse.Specifically, the facility failed to protect Resident #8 from physical abuse by Resident #22.Findings include:I. Facility policy and procedureThe Abuse Prevention policy, reviewed on 5/6/25, was received from the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It revealed in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally aggressive behavior, physically aggressive behavior, sexually aggressive behavior, taking, touching, or rummaging through other's property, wandering into others' rooms/space, residents with a history of self-injurious behaviors, residents with communication disorders or who speak a different language, and residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.II. Physical abuse of Resident #8 by Resident #22 on 7/1/25A. Facility investigationThe facility investigation was provided by the NHA on 8/12/25 at 9:03 a.m.The investigation documented that on 7/1/25 at 7:56 a.m., in the main dining room, certified nurse aide (CNA) #1 asked Resident #22 if she could move him in order to make room for Resident #8 to get to a table in the dining room. When Resident #22 was moved, he turned himself around in his wheelchair and placed both hands on Resident #8 chest, pushing him backwards. Resident #8 left the dining room and went to his room. Staff assessed Resident #8 for injuries and none were observed. Resident #22 was placed on one-to-one monitoring following the event while an investigation was being completed. CNA #1's eyewitness statement, dated 7/1/25, documented that CNA #1 had asked Resident #22 if she could move him to allow Resident #8 access to a table in the dining room. Resident #22 told CNA #2 sure go ahead and try while laughing. CNA #2 moved Resident #2 to the side and when she went to move Resident #8, Resident #22 had turned around towards Resident #8 and put both hands on Resident #8's chest, slamming him backwards in his wheelchair. Resident #8's wheelchair rolled backwards and Resident #8 was heard yelling no and took off out of the dining room.CNA #1 said Resident #22 hollered Do not be moving me! CNA #1 informed Resident #22 she had asked his permission prior to moving him and that no one had touched him other than her. Resident #22 responded that if anyone touched him, he would make them regret it.CNA #1 said she found Resident #8 in his room and he had two hand prints on his chest. Resident #8 returned to the dining room but was shaking and scanning the dining room for Resident #22.Resident #22 was taken to a table in the corner of the dining room away from Resident #8.The social services director (SSD) attempted to interview Resident #8 but he had no response and left the room.Resident #22 was interviewed by social services and he had no recollection of the event. The facility completed staff, resident and family representative interviews and no other abuse concerns were identified. The police, the physicians, the ombudsman and the family representatives were all informed of the incident. Resident #22 remained on-one-to one monitoring for 72-hours until the interdisciplinary team (IDT) met and concluded one-to-one monitoring was no longer needed as Resident #22 had not exhibited any other behaviors.The facility substantiated the abuse allegation as it was witnessed by staff. B. Resident #8 (victim)1. Resident statusResident #8, age greater than 65 was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included neurocognitive disorder (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(decline in cognitive function, including memory, thinking, and reasoning), dementia and rhabdomyolysis (damaged muscle tissue breakdown).The 6/16/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. The resident had unclear speech, was sometimes understood and sometimes understood others. The MDS assessment indicated the resident had no behaviors.2. Record reviewThe comprehensive care plan, initiated 6/16/25, documented Resident #8 had a behavior problem of wandering, trying to look out windows and not being aware of others' personal space related to frontal temporal lobe dementia. The goal was that Resident #8 would not experience behaviors that were harmful to himself or others. Interventions included administering medications as needed, anticipating the resident's needs, redirecting the resident away from other residents' rooms, intervening as necessary to protect the rights and safety of others by approaching/speaking in a calm manner to divert attention and removing the resident from the situation and taking him to alternative locations as needed.An event note, dated 7/1/25 at 1:03 p.m., documented another resident (Resident #22) placed both hands on Resident #8's chest and pushed him backwards in his wheelchair, causing the wheelchair to roll backwards. Resident #22 stated Do not be moving me. If anyone touches me they will regret it. Resident #8 left the dining room and went to his room. No injuries were noted and the family was notified.An alert note, dated 7/1/25 at 11:59 p.m., documented Resident #8 did not have any signs of latent injuries from the event on 7/1/25.An alert note, dated 7/2/25 at 12:16 p.m., documented Resident #8 had no signs of latent injuries to the upper body/chest post-incident on 7/1/25. He had no signs of pain or discomfort. The resident had no crying, groaning or facial grimacing.A skin integrity assessment completed on 7/1/25 revealed no changes in Resident #8's skin post-incident.C. Resident # 22 (assailant) 1. Resident statusResident #22, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, hypertension (high blood pressure) and dysphagia (difficulty swallowing). The 6/24/25 MDS assessment revealed the resident had long-term and short-term memory problems. The MDS assessment indicated the resident had physical and verbal behaviors directed towards others. 2. Record reviewThe comprehensive care plan, initiated 12/29/22, revealed Resident #22 had dementia with agitation and could exhibit impulsive behaviors, agitation/restlessness, not sleeping, verbal aggression wandering and rummaging. Identified goals were for Resident #22 to have fewer behavioral episodes. Interventions included administering medications, decreasing stimulation, offering calm environments, encouraging participation in activities, offering choices, explaining tasks, monitoring wandering behaviors, escorting the resident to an appropriate location, one-to-one supervision from 7/1/25 to 7/4/25 and redirecting the resident when he was agitated or when other residents were agitated in his vicinity.The comprehensive care plan further documented Resident #22 had the potential to be physically aggressive, including hitting, grabbing and pushing, related to dementia. Interventions included assessing and anticipating the resident's needs, providing physical and verbal cues to alleviate anxiety by giving positive feedback, assisting the resident with verbalization of sources of agitation and assisting the resident to set goals for more pleasant behaviors. Resident #22's triggers for physical aggression were related to incontinence, poor approach, elevated voice and close proximity of his personal space. A behavior note, dated 7/1/25 at 12:41 p.m. revealed CNA #1 informed the nurse that during breakfast in the dining room, she had asked Resident #22 if she could move him to make room at the table and after the resident was moved, he turned around in his wheelchair and put both hands on Resident #8's chest, pushing him backwards in his wheelchair, causing the wheelchair to roll backwards. Resident #22 stated Do not be moving me. If anyone touches me they will regret it. Resident #22 was moved to a separate table away from other residents to complete the meal. A one-to-one monitor was initiated. III. Staff interviewsCNA #1 was interviewed on 8/13/25 at 9:45 a.m. CNA #1 said Resident #8 kept to himself and was not very talkative. She said he would sometimes mumble and groan, causing other residents to become frustrated as he could not speak. CNA #1 said in July 2025 another resident, Resident #22, was in a grumpy mood and pushed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 in the chest. CNA #1 said for a while, Resident #8 avoided Resident #22 but now the two residents seemed to be okay with each other, as if they forgot it happened due to their dementia. CNA #1 said Resident #22 became aggressive if someone talked to him the wrong way or bumped into him the wrong way. She said he would get verbally aggressive and sometimes physically aggressive towards others. CNA #1 said he had behaviors throughout the day. CNA #1 said she had received online training and in-services on dementia and how to care for residents with different approaches. CNA #1 said it was good to have refresher training as the facility had new staff and all staff needed to know how to handle situations and residents. Registered nurse (RN) #1 was interviewed on 8/13/25 at 10:52 a.m. RN #1 said Resident #8 liked to roam from his room into the room across the hall, which was empty, to look out the windows. RN #1 said Resident #8 was a victim in a resident-to-resident altercation with Resident #22 in July 2025. She said Resident #22 had pushed Resident #8 in the chest. RN #1 said Resident #8 seemed to be at baseline and had not shown fear of Resident #22 since the incident.CNA #4 was interviewed on 8/13/25 at 10:54 a.m. CNA #4 said Resident #22 had aggressive behaviors related to Alzheimer's disease. She said the resident would shove people or staff away. CNA #4 said when he acted like that, staff had to divert his behaviors for safety reasons. CNA #4 said she received yearly training on abuse and how to approach dementia residents, along with training on verbal altercations and how to report a situation following the chain of command.The SSD was interviewed on 8/13/25 at 3:42 p.m. The SSD said Resident #8 had no aggressive behaviors. She said he just liked to go from his room to the room across the hallway to look out the window. The SSD said Resident #8 and Resident #22 had an altercation in the dining room on 7/1/25 where Resident #22 pushed Resident #8 in the chest. The SSD said both residents were cognitively impaired and Resident #8 got into Resident #22's personal space. The SSD said Resident #8 did not seem frightened or scared after the event and he resumed his normal activities. The SSD said Resident #8 was observed for behaviors via his body language for how he was coping post-incident, because he did not speak. The director of nursing (DON) was interviewed on 8/13/25 at 3:55 p.m. The DON said Resident #22 had dementia and if he was out and about and someone messed with something of his, he was going to fight. She said Resident #22 was physical towards staff and these were not new behaviors for him. She said Resident #22 had had a few incidents with residents. The DON said Resident #8 liked to wander from his room to the room across the hall to look out the window. The DON said Resident #8 was in the dining room (on 7/1/25) when Resident #22 pushed him with both hands on his chest. She said Resident #8 was shocked by the initial push and left the dining room and went to his room. She said Resident #8 left the dining room and when asked about the incident, he was unable to verbalize the incident due to his cognitive impairment. The DON said Resident #8 was not observed to have any behavior changed post-incident and he resumed his daily activities once he returned to the dining room. The DON said Resident #8 and Resident #22 were separated immediately and Resident #22 was placed on one-to-one monitoring for 72-hours.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to assess, arrange, and document discharge services for one (#32) of one resident reviewed for discharges out of 28 sample residents.Specifically the facility failed to provide Resident #32 with a bed hold policy at the time of the resident's transfer to the hospital.Findings include:I. Facility policy and procedureThe Area of Focus: Discharge Process and Bed Holds policy and procedure, revised 11/19/24, was received from the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It revealed in pertinent part, Transfers or discharges include movement of a resident to a bed outside of the certified facility. Bed hold: holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. Notice before transfer: before the facility transfers the resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility, the reserve bed payment policy in the state plan,if any, the nursing facility's policies regarding bed hold periods, which may be consistent with the transfer and discharge policy, permitting a resident to return and the information specified in the transfer and discharge policy. Bed hold policies will be provided and explained to the resident or responsible party upon admission and explained to the patient before each temporary absence. Before the resident is transferred to a hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident or responsible party that specifies the duration of the bed hold policy, during which the resident is permitted to return and resume residence in the nursing facility, the reserved bed payment policy in the state plan, if any, the facility's policy regarding bed hold. In cases of emergency transfers, notice at the time of transfer means that the family, surrogate, or responsible party are provided with written notification within 24 hours of the transfer. II. Resident #32A. Resident statusResident #32, age greater than 65, was admitted on [DATE], readmitted on [DATE] and discharged on 5/30/25 to the hospital. According to the May 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease, chronic obstructive pulmonary disease (COPD - ineffective oxygen exchange in the lungs), dysphagia (difficulty swallowing) and hypertension (high blood pressure).The 3/19/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He required partial/moderate staff assistance with dressing, personal hygiene and transfers. Set up assistance was needed for eating and toileting. B. Record reviewReview of the discharge care plan, initiated 3/15/25, revealed Resident #32 wished to remain in the facility for long-term care due to his 24-hour care needs.An event note, dated 5/30/25 at 7:42 p.m. documented the staff heard a loud thud coming from the hallway followed by a scream. Resident #32 was found on the floor outside of the nurses' station lying on his stomach with his wheelchair behind him. Resident #32 was not awake and when stimulated he opened his eyes.The resident had a golf ball-sized red area to his right forehead just above the eye with a small amount of bleeding observed. A registered nurse (RN) called an ambulance to have the resident taken to the hospital.-There was no documentation in Resident #32's electronic medical record (EMR) to indicate the resident or his representative were provided with a bed hold policy at the time of his transfer to the hospital.The NHA provided a bed hold policy signed by Resident #32 on 8/13/25 at 3:54 p.m. The signed bed hold policy indicated the resident signed the bed hold policy on 7/28/23, which was the resident's initial admission date to the facility.-The facility was unable to provide a bed hold policy that was signed by the resident or the resident's representative at the time of Resident #32's transfer to the hospital on 5/30/25. III. Staff interviewsRN #1 was interviewed on 8/13/25 at 10:50 a.m. RN #1 said it was the responsibility of the nurse who sent the resident out to the hospital to provide the bed (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hold policy to the resident or the resident's representative. RN #1 said it was a requirement to complete the bed hold. RN #1 said the resident or the resident's representative did not have to sign the form, but they had to be provided with the form. RN #1 said it was important residents had the bed hold policy information to ensure they would have a bed for them to return to if they chose to return to the facility. The director of nursing (DON) was interviewed on 4/13/25 at 4:23 p.m. The DON said the nurse sending the resident to the hospital was responsible for giving the resident or the resident's representative the bed hold policy at the time of the transfer to the hospital. The DON said the facility provided a bed hold policy for Resident #32 (on 5/30/25), however, she said the dates did not match. The DON said she called the nurse (during the survey) who had sent the resident to the hospital on 5/30/25 and the nurse informed her the number five on the form looked like the number seven. She said the nurse told her it was just her hand writing but the number seven should be a number five. -However, the date on the form provided by the facility on 8/13/25 (see record review above) was written as 7/28/23 and did not match up with the resident's transfer date of 5/30/25.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain proper personal hygiene for one (#14) of two residents reviewed out of 28 sample residents. Specifically, the facility failed to ensure a safe transfer was performed with Resident #14 who was dependent on staff. Findings include: I. Facility policy and procedureThe Activities of Daily Living policy and procedure, revised 2/12/24 was provided by the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It read in pertinent part, Utilize appropriate safety measures and any necessary equipment to maintain resident safety.The Limited Lift Program policy and procedure, revised 2/20/24, was provided by the NHA on 8/14/25 at 1:15 p.m. It read in pertinent part, The facility will assess residents for the need for assistance with transfer activities, mobility or repositioning utilizing a validated mobility assessment by either nursing or therapy. Manual lifting of all residents who are unable to bear weight will be minimized. II. Resident #14A. Resident statusResident #14, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included quadriplegia (paralysis of all four limbs), a history of traumatic brain injury and injury of cervical spinal cord. The 5/22/25 minimum data set (MDS) assessment revealed Resident #14 was unable to complete the brief interview for mental status. The staff assessment revealed he had short-term and long-term memory deficits. The staff assessment further revealed he was severely impaired in his daily decision-making. The MDS assessment revealed Resident #14 was fully dependent on staff for all of his ADLs. B. ObservationsDuring a continuous observation on 8/12/25, beginning at 9:36 a.m. and ending at 9:59 a.m. the following was observed:At 9:36 a.m. certified nurse aide (CNA) #2 entered Resident #14's room with the shower chair. A second unidentified CNA entered the room without a Hoyer lift (full body mechanical lift). Resident #14 was in his Geri-chair (a specialized wheelchair that reclines) in his room. At approximately 9:40 a.m. the two CNAs assisted Resident #14 into the shower room, the unknown CNA left the shower room. Resident #14 was in the shower chair.At approximately 9:41 a.m. the Hoyer lift was not inside of Resident #14's room. At 9:48 a.m. Resident #14 returned to his room in the shower chair.At 9:50 a.m. an unidentified CNA entered Resident #14's room without the Hoyer lift. At 9:59 a.m. two CNAs left Resident #14's room. Resident #14 was in his Geri-chair (a specialized wheelchair that can recline) The Hoyer lift was not in the room. -Resident #14 was transferred without using the Hoyer lift as recommended . C. Record reviewThe ADL care plan, revised on 6/3/25, documented Resident #14 had a self-care performance deficit related to his quadriplegia and was dependent on one to two staff for all of his ADL. The care plan documented Resident #14 was totally dependent on two staff for transferring using the Hoyer lift only. The functional goal care plan, revised 7/7/25, documented Resident #14 had limited physical mobility related to his contractures on his left hand and both lower extremities. The care plan documented that staff were to assist with all transfers using the Hoyer lift. The nursing admission assessment, dated 5/19/25 documented Resident #14 required maximum assistance with two staff using the Hoyer lift for transfers. The assessment documented Resident #14 was unable to standD. Staff interviewsCNA #1 was interviewed on 8/13/25 at 9:20 a.m. She said Resident #14 required a Hoyer lift or an extensive two-person lift when he was transferred. Registered nurse (RN) #1 was interviewed on 8/13/25 at 9:40 a.m. RN #1 said Resident #14 was a two-person Hoyer lift for transfers. She said the CNAs used the Hoyer lift every time he was transferred. CNA #2 was interviewed on 8/13/25 at 10:05 a.m. She said Resident #14 was a two-person Hoyer lift except for when he was super agitated. She said when he got agitated, they would use two or three people to transfer him without the Hoyer lift.Physical therapist assistant (PTA) #1 was interviewed on 8/13/25 at 10:17 a.m. She said Resident #14 was a two-person Hoyer lift for all of his transfers. The director of rehabilitation (DOR) was interviewed on 8/13/25 at 10:20 a.m. He said he did not do the assessment for the Hoyer lift. He said (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 came from another facility with the recommendation to use the Hoyer lift for transfers. He said the Hoyer lift should be used all the time. He said if staff did not use the Hoyer lift, then there would be the potential for the staff or the resident to become injured. The director of nursing (DON) was interviewed on 8/13/25 at 11:46 a.m. She said Resident #14 should be transferred with the Hoyer lift every time. She said she was unaware of anyone transferring Resident #14 without the Hoyer lift. She said that if staff were not using the Hoyer lift, there was the risk of the staff or the resident to become injured. CNA #2 was interviewed again on 8/13/25 at 2:13 p.m. She said they did a three-person transfer on 8/12/25 with Resident #14 because the resident had grabbed the Hoyer lift earlier in the morning. She said the way they performed the three-person lift was one person was behind the lifting under his arm pits and one person on each of his legs lifting. She said Resident #14's behavior of grabbing the lift had increased and if someone were to mention it to the DON then she would have him reevaluated. CNA #2 was interviewed a third time on 8/13/25 at 2:20 p.m. She said she had just spoken to the DON and said there was miscommunication. She said the CNAs thought therapy had already reevaluated Resident #14 and had given the go ahead to the two-person transfer. The DOR was interviewed again on 8/13/25 at 2:33 p.m. He said the correct way to do a two-person transfer was to put the gait belt around their waist, then have one employee in the front to do the stand-pivot-transfer and the second employee would be in back to help guide the resident. He said for a person who could not bear weight, it was not recommended to do a two-person transfer. He said Resident #14 could not bear weight and he would not recommend a two-person transfer for Resident #14. The DON was interviewed again on 8/13/25 at 2:51 p.m. She said the CNAs should not be transferring Resident #14 without the Hoyer lift. She said she began re-educating the staff and would continue to re-educate the staff until all of the CNAs and nurses have had the training. She said she was informed about Resident #14 grabbing the lift she said she would have therapy reassess him to see what they could do about his transfers.

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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 record review and interviews, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or prevent further decrease in ROM for two (#2 and #14) of three residents reviewed for restorative services out of 28 sample residents.Specifically, the facility failed to:-Ensure Resident #2 and Resident #14 were offered and provided with a restorative nursing program to maintain and/or prevent deterioration of their current levels of function and mobility; and,-Ensure Resident #14 was provided with a splint, palm guard or a rolled wash cloth in his left hand to prevent potential worsening of his hand contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).Findings include: I. Facility policy and procedure The Area of Focus: Restorative Nursing policy and procedure, revised 1/3/25, was received by the nursing home administrator (NHA) on 8/15/25 at 1:15 p.m. It read in pertinent part, Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. The restorative nursing program is based on the resident assessment instrument (RAI) user's manual. Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity. Other staff or volunteers who are trained may be assigned to work with specific residents. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living (ADL) do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Restorative nursing functions can be within one of the following categories: -Range of motion (active and passive); -Splint or brace assistance; -Bed mobility; -Transfers; -Walking; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dressing and/or grooming; -Eating and/or swallowing; -Amputation/prosthesis care; -Communication; -Toileting program; and, -Bladder retraining. The trained certified nurse aide (CNA) will document provided techniques per the restorative care plan in the medical record. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included central cord syndrome at an unspecified level of cervical spinal cord and Parkinson's disease. The 5/22/25 minimum data set (MDS) assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented Resident #2 was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, putting on/taking off footwear, sitting to lying and chair/bed to chair transfers. B. Resident interview Resident #2 was interviewed on 8/10/25 at 7:10 p.m. Resident #2 said he was supposed to start getting restorative services at the beginning of August 2025. He said he had not received any restorative services. He said he would like to receive restorative services to help with his mobility. C. Record review The ADL care plan, revised 12/5/24, documented Resident #2 had self care performance deficits related to central spinal cord syndrome, tetraplegia (the function or loss of motor and/or sensory function in the cervical area of the spinal cord), Parkinson's disease and neuralgia (symptom of severe nerve pain) and neuritis (inflammation of a nerve). Interventions included providing extensive one to two-person assistance for bed mobility to turn and reposition the resident in bed and providing total two-person staff assistance for transferring Resident #2 using a Hoyer lift (mechanical lift). The functional goal care plan, revised 11/27/24, documented Resident #2 had limited physical mobility. Interventions included providing gentle ROM as tolerated, providing a nursing rehab/restorative active range of motion (AROM) program, which included AROM to the upper extremities for 10-20 repetitions times two sets using Theraband (a brand of elastic resistance bands used for physical therapy, rehabilitation, and exercise), incorporating one to two pound weights as tolerated, gentle upward and outward 10-15 second stretches to the left upper extremity three to four (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times and providing a nursing rehab/restorative passive range of motion (PROM) program, which included PROM to both lower extremities for five to 10 repetitions times two sets as tolerated and gentle stretching. The nursing restorative program evaluation, dated 1/11/25, documented Resident #2 was provided restorative nursing services for PROM for transfers. The nursing restorative program evaluation, dated 2/14/25, documented Resident #2 was provided restorative nursing services for AROM related to decreased mobility and self care deficits due to weakness. Resident #2 additionally received PROM to maintain flexibility and prevent contractures to bilateral lower extremities (BLE). The nursing restorative program note, dated 3/3/25, documented stretching exercises for lower upper extremities were added to Resident #2's restorative program routine and added to his plan of care. The nursing restorative program evaluation, dated 3/24/25, documented Resident #2 was provided restorative nursing services for AROM due to decreased mobility and self care deficits due to weakness. Resident #2 additionally received PROM to maintain flexibility and prevent contractures to BLE. The nursing restorative program evaluation, dated 7/3/25, documented Resident #2 was provided restorative nursing services for AROM related to decreased mobility and self care deficits due to weakness. Resident #2 received PROM to maintain flexibility and prevent contractures to BLE. -Review of Resident #2's electronic medical record (EMR) revealed there were no nursing restorative program evaluations for the months of April 2025, May 2025, June 2025 or August 2025. -Review of Resident #2's EMR failed to reveal progress notes or other documentation to indicate the resident had received restorative program services for the months of April 2025, May 2025, June 2025 or August 2025. -A review of Resident #2's August 2025 CPO did not reveal a physician's orders for restorative program services. D. Staff interviews CNA #1 was interviewed on 8/13/25 at 1:26 p.m. CNA #1 said she did not know if staff was providing ROM for Resident #2. She said the facility was working on getting restorative staff hired. She said there had not been a restorative aide in the facility for two or more weeks. CNA #3 was interviewed on 8/13/25 at 1:50 p.m. CNA #3 said she did not know how long there had been no restorative aide in the facility. CNA #3 said the facility had hired someone for the position who would be starting soon. CNA #3 said restorative care was important for residents because it helped with maintaining and keeping their mobility. Licensed practical nurse (LPN) #1 was interviewed on 8/13/25 at 2:03 p.m. LPN #1 said CNAs were responsible for providing restorative services to residents. LPN #1 said Resident #2 had not been receiving restorative services, but he had received restorative services in the past. She said there had been no restorative aides in the facility for six weeks. She said the facility had a staff member in (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mind to train for the restorative aide role and that staff member would be starting soon. The director of rehabilitation (DOR) was interviewed on 8/13/25 at 3:00 p.m. The DOR said Resident #2 was not currently receiving physical therapy. The DOR said he did not know if Resident #2 was receiving restorative services. The DOR said he was familiar with Resident #2 and said he could benefit from restorative services. The DOR said restorative services had not been consistent for residents for the last couple of months. He said the facility had hired someone to fill the role who would be starting on 8/18/25. The MDS coordinator was interviewed on 8/13/25 at 3:25 p.m. The MDS coordinator said there had not been a consistent restorative aide in the facility since the last one left a couple of months ago. The MDS coordinator said staffing was short, so there was no one to help with restorative services. The MDS coordinator said a new restorative aide was starting on 8/18/25. The MDS coordinator said Resident #2 was placed on a restorative program shortly after he was admitted to the facility. She said she tried to get him on restorative services quickly. She said Resident #2 benefited from getting restorative services. She said Resident #2 was not currently receiving restorative services. The director of nursing (DON) was interviewed on 8/13/25 at 3:36 p.m. The DON said when a resident was coming off physical therapy services, a physician's order would be written for continued restorative services. The DON said it was important for residents to continue with restorative services so that residents did not lose strength or endurance. The DON said the facility had not had a restorative services program for six weeks. She said the facility had just hired a restorative aide and would now be able to start a complete restorative services program. She said the facility's restorative services program was currently being set up and the facility would soon be able to offer restorative services again. The DON said Resident #2 would benefit from restorative services. The DON said Resident #2 would be receiving restorative services three to five times a week. She said Resident #2 needed to have restorative services for ROM because of him being bed-bound. III. Resident #14 A. Resident status Resident #14, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included quadriplegia (paralysis of all four limbs), a history of traumatic brain injury, and injury of the cervical spinal cord. The 5/22/25 MDS assessment revealed Resident #14 was unable to complete the BIMS assessment. The staff assessment for mental status revealed he had short-term and long-term memory deficits. The staff assessment further revealed he was severely impaired in his daily decision-making skills. The MDS assessment revealed Resident #14 was fully dependent on staff for all of his ADLs and had ROM on both sides of his upper and lower extremities. B. Observations (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/10/25 at 4:55 p.m. Resident #14 was in the dining room. His left hand was contracted and the tips of his fingers were touching the palm of his hand. He did not have a splint, palm guard or a rolled washcloth in his hand. During a continuous observation on 8/11/25, beginning at 9:08 a.m. and ending at 11:47 a.m., the following was observed: At 9:08 a.m. Resident #14 was brought to his room from the dining room in his Geri-chair (specialized wheelchair that can recline). He did not have a splint, palm guard or a rolled washcloth in his left hand. At 10:23 a.m. Resident #14 was still in his room. An unidentified certified nurse aide (CNA) entered the room to answer his roommate's call light. At 10:45 a.m. the unidentified CNA left the room after assisting Resident #14's roommate. The unidentified CNA did not offer to apply a splint, palm guard or a rolled washcloth to Resident #14's left hand or offer to perform any ROM exercises with him. At 10:51 a.m. another unidentified CNA went into Resident #14's room and talked to him, however, she did not do any ROM exercises with him and did not apply a splint, palm guard or a rolled washcloth to his left hand. At 11:24 a.m. Resident #14 continued to sit in his chair in his room. No staff members offered to do ROM exercises with the resident or apply a splint, palm guard or a rolled washcloth to his left hand. At 11:47 a.m. Resident #14 was taken to the dining room for lunch. The resident's left hand did not have a splint, palm guard or a rolled washcloth applied. During a continuous observation on 8/11/25, beginning at 2:10 p.m. and ending at 4:50 p.m., the following was observed: At 2:10 p.m. Resident #14 was in his room in his Geri-chair. The resident's left hand did not have a splint, palm guard or a rolled washcloth applied. At 2:49 p.m. registered nurse (RN) #1 entered Resident #14's room and administered medications to the resident. She did not apply a splint, palm guard or a rolled washcloth to his left hand. At 3:22 p.m. Resident #14 remained in his room in his Geri-chair. His left hand did not have a splint, palm guard or a rolled washcloth applied and ROM exercises had not been performed. At 3:55 p.m. Resident #14 was still in his room in his Geri-chair. The resident's left hand did not have a splint, palm guard or a rolled washcloth applied and ROM exercises had not been performed. At 4:11 p.m. RN #1 entered Resident #14's room again and administered additional medications to the resident. She did not apply a splint, palm guard or a rolled washcloth to his hand. At 4:50 p.m. an unknown CNA took Resident #14 to the dining room for dinner The resident did not have a splint, palm guard or a rolled washcloth in his left hand and ROM had not been performed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Resident representative interview Resident #14's representative was interviewed on 8/11/25 at 12:25 p.m. The representative said she was unsure if Resident #14 was getting any restorative care for his contractures. She said the facility was going to have a care conference for him in a couple of weeks and she would find out then. D. Record review The ADL care plan, revised 6/3/25 documented Resident #14 had a self-care performance deficit related to his quadriplegia. Interventions included a nursing restorative program using a splint or brace and washing his left hand with soap and warm water, drying the left hand thoroughly, inspecting the hand for redness and skin breakdown and placing a rolled washcloth into his hand. The functional goal care plan, revised 7/7/25, documented Resident #14 had limited physical mobility related to the contracture of his left hand and both lower extremities. Interventions included a nursing restorative program of passive ROM on both his upper and lower extremities and performing gentle 15-20 second stretches to every joint for three to five repetitions. The restorative program evaluation, dated 6/28/25, documented the passive range of motion (PROM) restorative program was implemented for Resident #14 due to his decreased mobility related to his neurologic dysfunction and head trauma and the contracture of his left hand. The splint or brace program was also implemented because of the contracture of his left hand. -However, there was no documentation in Resident #14's EMR to indicate the resident had received a PROM restorative program from 6/28/25 to 8/11/25. E. Staff interviews CNA #1 was interviewed on 8/13/25 at 9:20 a.m. CNA #1 said Resident #14 was not receiving restorative programming. She said she did not know why. She said CNAs tried to do ROM with him when they were getting him dressed. She said she thought he might not be getting any restorative programming because he might be too hard for them to work with because he could become really aggressive. RN #1 was interviewed on 8/13/25 at 9:40 a.m. RN #1 said Resident #14 was receiving restorative services when he first got to the facility. She said the facility did not have the staff for the restorative program at that time. She said once the facility had the staff for the program, Resident #14 would be back on the program. CNA #2 was interviewed on 8/13/25 at 10:05 a.m. CNA #2 said she did not think Resident #14 received any kind of therapy. She said he did have a contracture of his left hand, but she thought it was permanent. Physical therapy assistant (PTA) #1 was interviewed on 8/13/25 at 10:17 a.m. PTA #1 said Resident #14 was not receiving any restorative services because the program had not started yet. She said the program would start the week of August 18th. The MDS coordinator was interviewed on 8/13/25 at 10:47 a.m. The MDS coordinator said the facility had Resident #14 on a restorative program but it was really inconsistent because of CNAs leaving or (continued on next page)

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	065217	A. Building B. Wing	08/13/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being moved to the floor. She said she had hired a CNA to work six days a week to do restorative programs and she would be starting the week of August 18th. She said the facility did not have anyone to provide the restorative services in the interim. The director of nursing (DON) was interviewed on 8/13/25 at 11:46 a.m. The DON said Resident #14 was on a restorative program but because of staffing, the facility had to pause the program. She said he had started the program sometime in June 2025and the program was paused sometime in July 2025. She said the program would start again the week of August 18th. She said some of the floor CNAs were trained to do restorative programs. The DON said when those CNAs who were trained to do restorative programs were working, they should be doing ROM and putting the washcloth in Resident #14's left hand.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review and interviews the facility failed to ensure residents were kept free of significant medication errors for one residents (#10) out of 28 sample residents. Specifically the facility failed to ensure insulin pens were primed prior to medication administration for Resident #10. Findings include:I. Professional referenceAccording to the Lantus (insulin Glargine) How to use your pen retrieved on 8/18/25 from https://www.lantus.com/dam/jcr:2cfa1d37-1b5d-445d-83cd-8eaaeaeef48b/lantus-quick-reference-patient-brocl It revealed in pertinent part, Step 3 perform a safety test. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that the insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times if there is still no insulin coming out, use a new needle and do the safety test again. The most common side effect of insulin, including Lantus (glargine) is low blood sugar (hypoglycemia) which may be serious and life threatening.II. Facility policy and procedureThe Administering of Medication policy, reviewed 9/16/24, was received from the nursing home administrator (NHA) on 8/14/25 at 1:15 p.m. It revealed in pertinent part, The facility will ensure medications are administered safely and appropriately per physician orders to address the residents diagnoses and signs and symptoms. Medication error, means the observed or identified preparation or administration of medication or biologics which is not in accordance with: the prescribers order; manufactures specification regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principals include the various practices regulations in each State, and current commonly accepted health standards established by national organizations, boards and councils. Significant medication, means one which causes the resident discomfort or jeopardizes his or her health and safety. Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medication in a skilled nursing facility. High alert medications include, but not limited to: Anticoagulants, chemotherapeutic agents, hypoglycemics, insulins, parenteral nutrition preparations and opioids.The Insulin Pen Administration policy, revised on 5/27/25, was received from the NHA on 8/14/25 at 1:14 p.m. It revealed in pertinent part, The facility will ensure residents with ordered for insulin administration through the use of pen delivery device is performed in accordance with current standards or practice and manufacturer's guidance. The insulin pen should be primed for each use (in accordance with manufacturer's guidelines) to prevent the collection of air in the insulin reservoir. General guidance on priming insulin pen in the absence of manufactures guidance. Dial 2 units by turning the dose selector clockwise, with the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of needle., If not repeat this procedure until at least one drop of insulin appears. III. Observations and staff interviewRegistered nurse (RN) #2 was observed on 8/10/25 at 7:14 p.m. preparing and administering medication to Resident #10. The physician's order read Glargine insulin inject 26 units subcutaneously two times a day for diabetes, ordered on 8/4/25.RN #2 collected the insulin pen, cleansed the top off with an alcohol swab and applied a new needle to the tip of the pen. She dialed the pen to 26 units at the medication cart. RN #2 took all medications prepared for Resident #10 including the insulin pen into the resident's room after donning (putting on) personal protective equipment (gown and gloves). Resident #10 took the oral medication whole with water. RN #2 then prepped the injection site with an alcohol swab, as RN #2 went to inject the insulin she was stopped and asked if she needed to prime the insulin pen. RN #2 said the type of pen and needle used did not require her to prime the insulin pen. RN #2 then continued to administer the insulin into the resident's right posterior upper arm. -RN #2 failed to prime the insulin pen (see professional reference above).IV. Additional staff interviewsThe director of nursing (DON) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was interviewed on 8/13/25 at 4:32 p.m. She said the nurses were to follow the seven rights of medication administration to ensure the correct medication was administered per physician orders. The DON said the nurses were to cleanse the top of an insulin pen with an alcohol swab and prime the needle with one unit. The DON said if the needle was not primed it could cause the wrong dose of insulin to be administered leading to hyperglycemia (high blood glucose) or hypoglycemia (low blood glucose levels).