STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065221	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Village Health and Rehabilitation Center	1000 E Stuart St Fort Collins, CO 80525

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to promote and maintain the residents' dignity for two (#45 and #57) of two residents reviewed for dignity and respect out of 29 sample residents Specifically, the facility failed to: -Ensure Resident #45 was offered his breakfast and lunch in a timely manner; and, -Ensure staff knocked and identified themselves prior to entering Resident #57's room. , Findings include: I. Resident #45 A. Resident status Resident #45, under age 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis, chronic obstructive pulmonary disease (COPD), emphysema, cervical disc degeneration and spondylosis (degeneration of the neck). According to the 1/4/24 minimum data set (MDS) assessment, Resident #45 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on assistance for toileting hygiene, bathing, dressing, and transfers, needed partial assistance for bed mobility and was independent with eating and oral and personal hygiene. The MDS assessment documented Resident #45 used a motorized scooter and was able to move about the facility independently once seated in his scooter. B. Resident interview and observations (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 was interviewed on 3/27/24 at 4:54 p.m. Resident #45 said he was not provided a lunch meal on 3/26/24 and had to go to the kitchen to order his meal himself. He said the staff forgot to give him a lunch meal tray. The following observations were made during a continuous observation on 4/1/24 beginning at 9:00 a.m. and ending at 10:00 a.m: On 4/1/24 at 9:00 a.m., staff were observed passing breakfast trays. An unidentified staff member said Resident #45 did not get a breakfast tray and she would make sure Resident #45 had something to eat. -However, a breakfast meal tray was not provided to Resident #45. At 10:00 a.m., Resident #45's call light was activated. Certified nurse aide (CNA) #4 entered Resident #45's room and asked Resident #45 what she could do for him. CNA #4 exited Resident #45's room and proceeded to the nourishment room where she obtained r two half peanut butter and jelly sandwiches. CNA #4 returned to Resident #45's room and gave him the two half peanut butter and jelly sandwiches. Resident #45 was interviewed again on 4/1/24 at 10:30 a.m. Resident #45 said the kitchen staff did not stay in the kitchen long after the breakfast service was over. He said the kitchen staff discarded the food after the meal was served and he doubted he would get anything to eat. He said he asked CNA #4 for a snack because he did not receive a breakfast tray. C. Staff interviews CNA #4 was interviewed on 4/2/24 at 8:49 a.m. CNA #4 said once the kitchen was finished with breakfast, residents were not able to order any more breakfast items because the food was discarded by the kitchen staff. CNA #4 said kitchen staff told facility staff it was too late to get any food after the meal had been discarded. CNA #4 said the kitchen did not always have the menu items listed on the alternate menu and if a resident needed food after lunch, the resident could get a peanut butter and jelly sandwich, a cold deli sandwich and sometimes a chef's salad was available CNA #4 said staff took residents' meal orders on their paper meal tickets and turned the meal tickets back into the kitchen. CNA #4 said there was not a system to ensure the resident's received their meal trays in their rooms but she said she walked the hallway she was assigned to in order to ensure the residents all received their meals. The dietary manager (DM) and nursing home administrator (NHA) were interviewed on 4/2/24 at 1:35 p.m. The DM said the facility did not have a verification process to ensure resident meal orders were taken and meal trays delivered. The DM said nursing staff usually took resident meal orders per hall and brought the completed orders to the kitchen. The DM said occasionally the kitchen received single resident meal orders after the majority of orders were already taken. The DM said residents' breakfast meal orders were taken in the morning prior to the breakfast meal service. The DM said residents could always request food between meals. -However, according to interviews with Resident #45 and CNA #4, the kitchen staff did not provide food for residents after the breakfast food had been discarded (see interview above). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and DM said they had not heard Resident #45 had not received his meal trays on 3/26/24 and on 4/1/24. The DM said he would ensure Resident # 45 had a meal ticket in the electronic menu system. The NHA said there was always something available for residents at breakfast and the kitchen staff could make eggs to order and provide toast, milk and fresh fruit, and coffee if any of the breakfast menu items were discarded. 48458 II. Resident #57 A. Facility policy The Resident Rights Guidelines for All Nursing Procedures policy, revised October 2010, was provided by quality mentor (QM) #1 on 4/1/24 at 4:45 p.m. It read in pertinent part, Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including resident dignity and respect. For any procedure that involves direct resident care, knock and gain permission before entering the resident's room. B. Resident status Resident #57, age less than 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included sepsis (infection), neuropathy (weakness, numbness and pain from nerve damage), asthma and respiratory failure. The 3/8/24 MDS assessment revealed Resident #57 was cognitively intact with a BIMS score of 15 out of 15. She was independent with eating, required supervision with dressing and moderate assistance with hygiene. C. Resident observation and interviews Resident #57 was interviewed on 3/27/24 at 1:20 p.m. She said the facility staff entered her room frequently without knocking. She said many staff did not identify themselves or wear name badges. On 3/27/24 at 1:23 p.m., an unidentified staff person, who was identified by Resident #57 as a physical therapist (PT), opened Resident #57's door without knocking and entered the room. The PT did not have a name badge on. Resident #57 was interviewed on 4/1/24 at 1:07 p.m. She said therapists and staff had continued to enter her room without knocking. D. Staff interviews CNA #4 was interviewed on 4/2/24 at 9:07 a.m. She said staff should knock on residents' doors prior to entering their rooms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/2/24 at 12:04 p.m. The DON said all staff should knock on residents' doors every time they wanted to enter the rooms. The director of rehabilitation (DRH) was interviewed on 4/2/24 at 2:25 p.m. The DRH said each staff member had a nametag and was expected to knock on the door prior to entering a resident's room.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48458 Based on observations, record review and interviews, the facility failed to provide assistance with activities of daily living (ADL) for three (#15, #37 and #60) of seven residents reviewed for ADLs out of 29 sample residents. Specifically, the facility failed to ensure Resident #15, #37 and #60 received showers as scheduled. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) policy, revised March 2018, was provided by quality mentor (QM) #1 on 4/1/24 at 4:45 p.m. It read in pertinent part, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way, at a different time, or having another staff member speak with the resident may be appropriate. II. Resident #15 A. Resident status Resident #15, age 79, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included respiratory failure, kidney disease, diabetes and anemia. The 3/20/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She had lower extremity impairment which required wheelchair use. Resident #15 required moderate assistance for oral hygiene and was dependent for tub and shower transferring, showering and dressing. The 9/24/23 MDS assessment revealed it was somewhat important to Resident #15 to choose between a tub bath, shower and bed bath. B. Resident interview (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15 was interviewed on 3/27/24 at 11:34 a.m. Resident #15 said she occasionally received a bed bath. She said she was beat up in a shower at a previous facility. She said she preferred to take a bath. She said the facility was aware she did not like showers but said she was told the bathtub was broken. She said she would use the bathtub if it were not broken. Resident #15 was tearful and anxious when she mentioned the shower incident at the previous facility. C. Record review Resident #15's care plan, revised 1/24/24, revealed Resident #15 was to be provided with a sponge bath when a full bath or shower was not tolerated and the resident's bathing preference was once per week. Review of the shower schedule posted at the nurses station revealed Resident #15 was scheduled to receive showers every week on Wednesday. -The shower schedule failed to document the resident preferred a bed bath or a bath over a shower. Review of the March 2024 CPO revealed the following physician's order documented in pertinent part: Ensure resident received her shower. If refused, place a progress note of interventions attempted every Wednesday night to ensure the shower was completed. -Progress notes revealed no documentation to indicate why the resident missed her showers or what interventions were attempted for Resident #15's missed showers in February 2024 or March 2024 (see bathing/showering record below). Resident #15's bathing/showering record was reviewed from 2/1/24 to 3/31/24 was provided by the director of nursing (DON) on 4/2/24 at 3:54 p.m. The bathing/showering record revealed Resident #15 refused one shower on 3/6/24. -There was no further documentation to indicate the resident had refused any other showers. -Per the bathing/showering record documentation, out of eight scheduled opportunities for showers for Resident #15 between 2/1/24 and 3/31/24, the resident did not receive any showers or sponge baths during the reviewed timeframe. D. Staff Interviews Certified nurse aide (CNA) #4 was interviewed on 4/1/24 at 2:27 p.m. CNA #4 said Resident #15 should receive showers every Wednesday evening per the posted schedule. She said there was a working bathtub at the facility. She said she was not aware Resident #15 did not like showers. CNA #4 said she did not know the last time Resident #15 had a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 4/2/24 at 12:16 p.m. The DON said she expected Resident #15 to receive four showers in a four week period provided the resident did not refuse. The DON said she was going to talk with Resident #15 about her showers, as she was not aware Resident #15 did not like showers and would prefer a bath or bed bath. III. Resident #37 A. Resident status Resident #37, age 88, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included kidney disease, low blood pressure, diabetes and epilepsy. The 3/6/24 MDS assessment revealed Resident #37 was cognitively intact with a BIMS score of 13 out of 15. He required moderate assistance with oral hygiene and substantial assistance with toileting, showering and dressing. The assessment revealed it was very important for Resident #37 to choose between a tub bath, shower and bed bath. B. Resident observation On 3/28/24 at 9:44 a.m., Resident #37 was observed sitting in his room with food on his pants and disheveled greasy hair. C. Record review Resident #37's care plan, revised 3/1/24, revealed Resident #37 required substantial/maximal assistance with showering. Review of the shower schedule posted at the nurses station revealed Resident #37 was scheduled to receive showers every week on Tuesdays and Fridays. Resident #37's bathing/showering record from 2/1/24 to 3/31/24was provided by the DON on 4/2/24 at 3:54 p. m. The bathing/showering record revealed the following: -Resident #37 refused to shower on 2/27/24 and 3/5/24 and was not available on 3/29/24 due to hospitalization ; and, -Resident #37 received showers on 2/2/24 and 2/16/24. -Per the bathing/showering record documentation, out of 16 scheduled opportunities for showers for Resident #37 from 2/1/24 to 3/31/24, the resident only received two showers during the reviewed timeframe. D. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #5 was interviewed on 4/2/24 at 8:43 a.m. CNA #5 said Resident #37 was one of the residents assigned to her during her shift. CNA #5 said she did not know how often he received his showers. CNA #4 was interviewed on 4/2/24 at 9:03 a.m. CNa #4 said Resident #37's shower schedule was changed from days to nights a few months ago. She said she did not think Resident #37 was getting his showers and the night shift staff were not providing showers for many residents. CNA #4 said Resident #37 looked like he needed a shower and his hair was not combed or groomed most of the time. The DON was interviewed on 4/2/24 at 12:08 p.m. The DON said she expected Resident #37 to receive eight showers in a four week period provided he did not refuse. She said there were no showers documented for Resident #37 over the past four weeks (from 2/1/24 to 3/31/24). 19262 IV. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE] and discharged on [DATE]. According to the February 2024 CPO, diagnoses included malignant neoplasm of the skin, essential hypertension, painful urination and fracture of the upper end of the left humerus with routine healing. The 11/8/23 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of 99 (unable to complete the interview) out of 15 with no behaviors. The resident had short and long-term memory problems. The resident was modified independence in cognitive skills for daily decision-making. The resident had physical impairments on both the upper and lower extremities. The resident was dependent on staff (resident did none of the effort to complete the task) for showers/bathing. B. Record review A physician's order dated 10/27/23 at 10:07 a.m. revealed to ensure the resident received her showers. If the resident refused a shower staff were to place a progress note of the interventions that were attempted on the Monday, Wednesday and Friday night shifts. The care plan for functional abilities/self-care/mobility performance deficit related to activity intolerance, confusion, disease process, impaired balance, polyneuropathy, and hard of hearing was initiated on 5/26/22 and revised on 2/2/24. The pertinent intervention revealed the resident was dependent on staff for showers/bathing and preferred bed baths. The resident's Kardex (electronic nursing document that summarized a resident's information, medications, clinical follow-up and daily care schedules) dated 2/4/24 (not timed) revealed the resident preferred a bed bath on Monday, Wednesday and Friday nights after dinner. The resident's bathing/showering record documentation from 1/20/24 to 2/2/24 was provided by the DON on 3/28/24 at 2:34 p.m. The documentation revealed the resident received one bath on 1/24/24 and not applicable (not provided) was documented on 1/31/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Per the bathing/showering record documentation, out of six opportunities for bathing for Resident #60 from 1/20/24 to 2/2/24, the resident only received one bath during the reviewed timeframe. C. Staff interview The DON was interviewed on 4/2/24 at approximately 2:30 p.m. The DON said the resident should receive three baths each week on Monday, Wednesday and Friday nights. She agreed with the provided information on the resident's bathing/showering documentation. The DON said the resident should have received a total of six baths from 1/20/24 through 2/2/24 and she did not. The DON said the documentation did not reveal the resident had refused any baths and there were no progress notes in the resident's clinical records that the resident had refused any baths during the 14 day period.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure residents were kept free from significant medication errors for one (#1) of six residents of 29 sample residents reviewed for medication errors. Specifically, the facility failed to ensure Resident #1 received all of his medications per the physician's orders. Findings include: I. Facility policy The Medication Administration Policy, dated 2/29/24, was provided by quality mentor (QM) #1 on 4/2/22 at 5:57 p.m. The policy revealed in pertinent part, Resident medications are administered in an accurate, safe, timely, and sanitary manner. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medication. Medications are administered in accordance with written orders of the attending physician or physician extender. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the resident's current diagnosis or condition, contact the physician for clarification prior to the administration of the medication. Document the interaction with the physician in the nursing progress notes and elsewhere in the medical record, as appropriate. Double-check the amount of medication to be administered. Medication is to be given in compliance with physician orders and or manufacturer's recommendations. Ensure the medication is administered via the right route. Record the results of medications administered per facility policy and procedure. Each time a medication is administered it must be documented. II. Resident status Resident #1, under age 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included paraplegia, sciatica, low blood pressure, epilepsy, major depressive disorder, anxiety disorder and morbid obesity. According to the 1/8/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on maximum assistance with toileting, showering, dressing, personal hygiene, bathing and transfers. He needed supervision for oral hygiene and set up help only with meals. III. Resident interview Resident #1 was interviewed on 3/28/24 at 2:00 p.m. Resident #1 said the facility had recently run out of his seizure medication for two days. He said he was told by the facility staff that the facility did not reorder the medication timely. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was interviewed again on 4/2/24 at 5:30 p.m. Resident #1 said he wished the facility would correct the issues with medications not being reordered on time. IV. Record review The April 2024 CPO revealed Resident #1 was prescribed the following medications: Zonisamide (medication used to treat seizures) capsule 100 mg; Resident #1 was prescribed four capsules by mouth at bedtime for epilepsy on 2/9/24. Linaclotide (medication used to treat irritable bowel syndrome and chronic constipation) oral capsule 290 mcg (microgram); Resident #1 was prescribed one capsule orally at bedtime for history of SBO (small bowel obstruction) on 2/9/24. Baclofen (a muscle relaxant) oral tablet 20 mg; Resident #1 was prescribed 20 mg orally four times a day for congenital hydrocephalus (fluid on the brain) on 2/9/24. -Bisacodyl (a laxative medication) tablet delayed release 5 mg; Resident #1 was prescribed one tablet by mouth one time a day for constipation on 2/9/24. A review of Resident #1's March 2024 medication administration record (MAR) and progress notes revealed the following medications were documented as not administered per the physician orders: On 3/25/24 Bisacodyl delayed release tablet was documented in the MAR as not administered with the charting code number nine, see other/progress notes. -A 3/25/24 progress note written at 9:34 a.m. documented Bisacodyl tablet delayed release five mg, give one tablet by mouth one time a day, medication was not available. -There was no documentation a provider was notified that the medication was unavailable. On 3/25/24 Baclofen oral tablet was documented in the MAR as not administered with the charting code number nine, see other/progress notes. -A 3/25/24 progress note written at 7:49 p.m. documented Baclofen oral tablet 20 mg, give 20 mg orally four times a day, medication was unavailable. -There was no documentation a provider was notified that the medication was unavailable. On 3/25/24 Linaclotide was documented in the MAR as not administered with the charting code number nine, see other/progress notes. -A 3/25/24 progress note written at 7:50 p.m. documented Linaclotide oral capsule 290 mg, give one capsule orally at bedtime, medication was unavailable. -There was no documentation a provider was notified that the medication was unavailable. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 Zonisamide was documented in the MAR as not administered with the charting code number nine, see other/progress notes. -A 3/28/24 progress note written at 7:55 p.m. documented Zonisamide 100 mg capsule, give four capsules by mouth at bedtime, medication was not here (at the facility). -There was no documentation a provider was notified that the medication was unavailable. V. Facility education A Medication Availability in-service dated 3/14/24 to 3/15/24 and 3/27/24 to 3/28/24 (during the survey) was provided by QM #1 on 4/2/24 at 5:58 p.m. The in-service documented the following education was provided to licensed nursing staff at the facility, If a medication is out of stock the provider must be notified. A nursing note must be written in the resident's electronic medical record. Call the provider and let them know the outcome of the investigation and what needs to be done. Document everything in a progress note. -However, the progress notes for Resident #1 revealed he was not administered single doses of three medications on 3/25/24 and one medication on 3/28/24 after education was provided to facility staff. -Despite the previously provided staff education, Resident #1's Zonisamide medication was documented as unavailable on 3/28/24 and there was no documentation a provider was notified. VI. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/1/24 at 3:30 p.m. LPN #1 said the date a medication was reordered in a resident's EMR. She said if a medication was reordered she sometimes had to call the pharmacy to check the status of the medication because it was needed for medication administration before the pharmacy delivered it. She said there had been delays receiving medications because the pharmacy would tell the facility staff they needed to verify a resident's insurance information before they could refill the medication. Certified nurse aide (CNA) #1 was interviewed on 4/2/24 at 9:00 a.m. CNA #1 said she was licensed to pass medications and was able to reorder medications. She said if a medication was unavailable in the facility to administer to a resident she would tell the charge nurse. CNA #1 said the facility had not been receiving some medications timely because of the pharmacy. CNA #1 said staff could contact the pharmacy at any time if needed. The director of nursing (DON) was interviewed on 4/2/24 at 3:49 p.m. The DON said the staff should notify a provider if the facility was out of a medication or unable to administer a medication so the provider could provide guidance for follow up steps. The DON said she would like to be notified if a medication should have arrived at the facility but did not so she could provide guidance to the staff and follow up with the pharmacy. The DON said the facility provided this education to the staff in March 2024. She said the facility started additional education on 3/28/24 and would continue to ensure all facility nurses were provided the education that a provider should be notified if a medication was not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said nurses should look at the last medication card when it was pulled from the medication cart to see if reordering the medication was necessary. The DON said if a medication was reordered, staff were able to see the pending medication order in the system and follow up with the pharmacy if needed. The DON said she was going to initiate more frequent conversations with nursing staff regarding the availability of medications and any issues the staff might be experiencing. The DON said she had not yet checked Resident #1's medications in the cart for verification the medications were unavailable at the time of ordered administration. V. Facility follow up The facility provided additional documentation of an in-service provided to LPN #1 on 4/1/24 (during the survey). The in-service documented if a medication was unavailable the note in the resident's EMR should say medication not administered, provider aware, no new orders or new orders if the orders were changed. The provider must be notified if it was a medication error. If the problem continued, the DON needed to be notified. -However, there were three nurses that documented the medications were not administered/available, but only one of the three nurses had been provided the education from the in-service.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure one (#13) of three residents reviewed for ancillary services, such as dental services, out of 29 sample residents received routine dental care obtaining routine and 24-hour emergency dental care. Specifically, the facility failed to provide Resident #13 with routine dental care. Findings include: I. Facility policy and procedure The Dental Services policy, revised December 2016, was provided by quality mentor (QM) #1 on 4/2/24 at 5:57 p.m. The policy revealed in pertinent part, Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentists or referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan if eligible. All dental services provided are recorded in the resident's medical record. II. Resident status Resident #13, age 85, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing), morbid obesity and major depressive disorder. According to the 1/29/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #13 was dependent on assistance for bathing, toileting hygiene, lower body dressing, and transfers. He needed supervision or touching assistance with eating, oral and personal hygiene, and moderate assistance with upper body dressing. III. Resident interview Resident #13 was interviewed on 3/27/24 at 1:14 p.m. Resident #13 said he had not been to a dental appointment in two years. Resident #13 said the facility staff did not ask the residents about appointments. He said the residents were only told if an appointment was set up. IV. Record review A review of Resident #13's electronic medical record (EMR) documented a physician order for dentist appointments as needed, ordered on 1/25/24. -However, the resident's EMR did not reveal the resident had been offered or provided access to dental care. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/2/24 at 8:49 a.m. She said Resident #13 did not request to see a dentist. The social services director (SSD) was interviewed on 4/2/24 at 9:30 a.m. The SSD said she did not have any documentation Resident #13 refused dental services and said Resident #13 had not been seen by a dentist. The SSD said Resident #13 was not in the building this year (2024) when residents signed consent forms for dental services, and Resident #13 did not sign a consent form for dental services previously. The SSD said the facility did not document resident refusals of dental services. V. Facility follow up The SSD reported on 4/2/24 at 9:35 a.m. Resident #13 had been added to the list to see a dentist at the end of April 2024.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47151 Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable, attractive and at a safe and appetizing temperature. Specifically, the facility failed to ensure resident food was served palatable in taste, texture and temperature. Findings include: I. Facility policy and procedure The Meal Preparation for Nutritive Value and Palatability policy, revised April 2023, was provided by quality mentor (QM) #1 on 4/1/24 at 6:38 p.m. The policy revealed in pertinent part, Food is prepared by methods that conserve nutritive value, flavor and appearance. Meal service is timed for tray/cart delivery within reasonable time limits to preserve temperature and quality of food. Resident's comments are noted in resident council meeting minutes with appropriate action taken per response or grievance form. II. Resident interviews Resident #15 was interviewed on 3/27/24 at 11:12 a.m. Resident #15 said some food tasted good but residents asked for more and sometimes the kitchen said they were out of the food item. Resident #43 was interviewed on 3/27/24 at 11:13 a.m. Resident #43 said she always ate in her room. She said the food was often cold and it did not taste good. She also said the food was often cooked too much until it was dried out. Resident #27 was interviewed on 3/27/24 at 1:14 p.m. Resident #27 said the food was of terrible quality, menu choices were terrible and food was cold. Resident #13 was interviewed on 3/27/14 at 1:15 p.m. Resident #13 said the food was terrible and delivered cold. Resident #44 was interviewed on 3/27/24 at 3:36 p.m. Resident #44 said the food usually did not taste or look good. She said the grilled ham and cheese sandwich had been cold and soggy the day before (3/26/24). Resident #57 was interviewed on 3/27/24 at 1:24 p.m. Resident #57 said the food tasted bad, was often cold and the milk was served warm. Resident #24 was interviewed on 3/27/24 at 5:07 p.m. Resident #24 said the menu was repetitive with a lot of hamburger dishes. She said hot foods were often served lukewarm and cold foods were sometimes served warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #42 was interviewed on 3/28/24 at 8:48 a.m. Resident #42 said everything about the food served at the facility was awful. Resident #43 was interviewed again 4/2/24 at 10:11 a.m. Resident #43 reiterated the food that was brought to her room was usually served cold. She said the meat was tough and she was unable to chew it very well. She said the vegetables were often over cooked and were mushy. She said the rice was often dry and she was served foods that she did not like. III. Group interview Five alert and oriented residents (#1, #2, #15, #24 and #51), selected by the facility, were interviewed in a group meeting on 3/28/24 at 2:00 p.m. Resident #15 said if residents lived farther down the hallway, the food was cold when it was delivered. He said the gravy was too salty. Resident #24 said her meal order was not always taken and staff would not wake her up to take her order if she was asleep. Resident #1 said he agreed with Resident #15 and his food was cold when it was delivered to his room. He said staff did not always take his orders for meals. Resident #24 said the food was too salty. IV. Record review Food committee meeting minutes from January 2024, February 2024 and March 2024 were provided by the dietary manager (DM) on 4/2/24 at 4:30 p.m. The 2/22/24 meeting minutes documented the food was cold at times. -All three months of meeting minutes were left blank in the section titled Residents interviewed in their room. V. Observations On 4/1/24 at 5:51 p.m. a test tray for a regular diet, which was served at the same time as resident room trays, was evaluated by two surveyors during the dinner meal service. The test tray was plated in the kitchen at 5:33 p.m., arrived on the unit at 5:38 p.m. and was tested for temperature and tasted prior to the last three residents on the unit being served their meals. The test tray meal consisted of butter crumb tilapia fillet, a baked potato with a side of sour cream, green peas, dinner roll and a blondie (a blonde brownie). Temperatures of the tilapia fillet, baked potato, and peas were taken immediately upon receipt of the test tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Only the baked potato, which had a temperature of 123 degrees fahrenheit (F), was within the acceptable palatable temperature of 120 degrees fahrenheit (F). The butter crumb tilapia and the peas were both below the acceptable palatable temperature of 120 degrees F. The temperatures were as follows: -The temperature of the peas was 108 degrees F. -The temperature of the butter crumb tilapia fillet was 107 degrees F. -The baked potato was overcooked and difficult to cut with a knife. It tasted burned on the bottom. -The edges of the crumb tilapia filet were chewy. VI. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/2/24 at 8:49 a.m. CNA #4 said when residents tried to order from the alternate menu the items were not always available. The registered dietitian (RD) was interviewed on 4/2/24 at 12:50 p.m. The RD said the staff ask each resident their food preferences for every meal and during this time, residents had the opportunity to make changes/choices to food items for that meal. The RD said when a meal tray was brought to residents in their rooms, residents had the opportunity to reject the meal and get a substitute plate of food. The RD said she was in the processes of updating preferences and it was an opportunity to meet with the residents one and one. She said none of the residents had told her the food was cold. The dietary manager (DM) was interviewed on 4/2/24 at 1:35 p.m. The DM said he had done test trays at the facility. The DM said he tried to pick up the last tray delivered on the room cart to test as much as possible because that was the tray that mattered the most with regards to temperature. The DM said he took the temperature of the food and tasted the food on the test tray and had not previously noted any issues with taste or temperature. The DM said he also tasted the food before it left the kitchen because the taste of the food was important. The DM said he had previously alternated how the room trays were delivered. The DM said he had not tried to use more than one meal delivery cart for the three hallways in the facility. The DM said a food meeting with the residents took place monthly and he had heard some small comments about the food but nothing resounding as it was usually the same person and not multiple residents. The DM said he had not spoken specifically to residents who dined in their rooms about food concerns. 19262

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, interviews and record review the facility failed to store, prepare, distribute, and serve food in a sanitary manner in the main kitchen, main dining room, one of two nourishment rooms and one of two units. Specifically, the facility failed to: -Ensure staff performed hand hygiene and glassware was handled appropriately in the main dining room; -Ensure staff washed hands and changed single use gloves appropriately while plating and serving resident meals in the main kitchen; -Ensure food was labeled and dated and disposed of timely in one of two nourishment rooms; and, -Ensure food items on meal trays were covered during transport in the hallway during meal delivery to resident rooms. Findings include: I. Ensure staff performed hand hygiene and glassware was handled appropriately in the main dining room. A. Professional references The Colorado Retail Food Regulations, effective [DATE], were retrieved [DATE] from https://cdphe.colorado.gov/environment/food-regulations. The regulations read in pertinent part, Single-service and single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food- and lip-contact surfaces is prevented. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings guidance, last reviewed [DATE], was retrieved on [DATE] from https://www.cdc.gov/handhygiene/providers/guideline.html. The guidance read in pertinent part, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient, before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. B. Facility policy and procedure (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Hand Hygiene Procedure guideline, undated, was provided by quality mentor (QM) #1 on [DATE] at 4:45 p.m. The guideline revealed in pertinent part, The procedure for performing hand hygiene: to dispense an antiseptic hand rub product, dispense an ample amount of the product into the palm of one hand. Rub your hands together, covering with the antiseptic solution on the palms and the back of your hands, interlocking your fingers, cleaning the thumb areas, and finishing with your wrists. Rub your hands together until the alcohol is dry. C. Observations The following observations were made on [DATE] during a continuous observation beginning at 11:15 a.m. and ending at 12:00 p.m. in the main dining room: -An unidentified staff member poured drinks for residents in the main dining room and failed to perform proper hand hygiene after his hands were contaminated during meal service. -At 11:17 a.m. an unidentified staff member touched the handles of a resident's wheelchair to assist the resident. The staff member did not perform hand hygiene before picking up a clean glass and carrying the glass over to a resident seated at a dining room table. While speaking to the resident, the staff member moved the glass from his right hand to his left hand and held the glass with his fingers over the mouthpiece. The staff member then carried the glass to a beverage station and poured milk into the glass. The staff member carried the glass of milk back to the resident with his index finger around the mouthpiece of the glass. The resident drank from the glass of milk. -At 11:24 a.m. the unidentified staff member set a water bottle and coffee cup on a dining room table where four residents were seated. As he spoke to the residents at the table, he took a drink from the coffee cup and then moved the coffee cup and water bottle to a different table in the dining room. -At 11:26 a.m., without sanitizing his hands, the unidentified staff member returned to the table he had previously brought a glass of milk to. The staff member picked up the partially consumed glass of milk with his left hand and his fingers around the mouthpiece. The staff member moved the glass into his right hand and continued to touch the mouthpiece with his fingers. The staff member put the glass into a bussing tub on a three tiered cart in the dining room. Without performing hand hygiene, the staff member lifted a clean glass with one hand and a pitcher of lemonade with the other and filled the glass. The staff member picked up the glass of lemonade with his right hand and his index finger around the mouthpiece of the glass. He delivered the glass of lemonade to a resident in the dining room. The resident drank from the glass. -At 11:28 a.m. the unidentified staff member drank from his coffee cup, then picked up his water bottle from the table and drank from his water bottle in the dining room before placing his water bottle back on the table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 11:31 a.m., without performing hand hygiene, the unidentified staff member entered the kitchen through the door by turning the door handle. He exited the kitchen and carried a piece of paper to a resident and told the resident the lunch menu. The staff member returned to the kitchen door and entered by turning the doorknob with his right hand and the paper in his left hand and left the paper in the kitchen. He exited through the same kitchen door and returned to the dining room again. Without performing hand hygiene, the staff member picked up a container of hand sanitizer wipes, removed a sanitizer wipe from the container and handed the resident the wipe. The staff member walked to another table in the dining room carrying the sanitizer wipes container. While standing next to a resident, he touched her back with his left hand. He then removed a sanitizer wipe from the container with his left hand and handed the resident a sanitizer wipe. -At 11:35 a.m. after using a sanitizer wipe to wipe her hands, the resident handed her used sanitizer wipe to the unidentified staff member. He took the used wipe and discarded it in a trash can. The staff member then pulled a clean sanitizer wipe from the container and handed the wipe to a resident. He went to offer another resident a wipe from the container. He carried the container of wipes to the table where his coffee cup and water bottle were and set the wipes down. He took a drink from his coffee cup and his water bottle and then another drink from his coffee cup. The staff member walked to the table with four residents and set his coffee cup on the table where the residents were seated, bent down and adjusted his pant legs with his hands and spoke to a resident. He then stood up, picked up his coffee cup with his right hand and then picked up his water bottle with his left hand and set his water bottle on a table in the dining room. -At 11:38 a.m. the unidentified staff member picked up his coffee cup by the mouthpiece with his fingertips, took a drink from the cup then carried the cup to the bussing tub on the three tier cart. Without performing hand hygiene, the staff member spoke to a resident and set his hand on the resident's wheelchair handle during the conversation. The staff member left the dining room, went to the kitchen door, turned the kitchen door handle and did not go in but instead walked into the hallway. He offered to get a resident a drink who was standing in the hallway outside the dining room. Without performing hand hygiene, the staff member came back to the dining room and grabbed a cup and a pitcher, poured fruit punch in the glass and placed the pitcher back in the tub of ice with other pitchers at the drink station. The staff member picked up another glass and poured cranberry juice in the glass and set the two drink glasses on the table, touching his fingers to the mouthpiece of the glasses while doing so. The staff member picked up a glass and a gallon milk container, poured a glass of milk and set the milk in front of the resident with the fruit punch and cranberry juice. -At 11:42 a.m. the unidentified staff member picked up a piece of paper from a dining room table, left the dining room and entered a room across the hall. -At 11:44 a.m. he exited the room with additional copies of paper and entered the dining room. He put one piece of paper back on a dining room table and exited the dining room with the additional papers in his hands. -At 11:45 a.m., without performing hand hygiene, the unidentified staff member returned to the dining room, picked up a hot beverage carafe and filled a coffee cup with the hot beverage. The staff member walked out of the dining room carrying the coffee cup with his right hand and fingers around the mouthpiece. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 11:46 a.m., without performing hand hygiene, the unidentified staff member came back to the dining room with a coffee cup in his hand and set it down in front of a resident. The staff member turned the kitchen door knob with his left hand and entered the kitchen. -At 11:48 a.m., without performing hand hygiene, the staff member was handed a meal tray, left the kitchen and delivered a meal to a resident in the main dining room. The staff member set the meal tray on the table, removed the plate from the tray and placed the plate on the table in front of the resident. The staff member carried the empty tray back to the kitchen. The staff member finally performed hand hygiene as he exited the kitchen. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on [DATE] at 4:35 p.m. CNA #4 said facility staff were trained on how to properly carry cups and glasses during meal service. CNA #4 said the facility did in-services for staff which covered how to properly hold the cups. CNA #4 said staff were educated not to put their fingers around the mouthpiece of the glasses. The activities director (AD) was interviewed on [DATE] at 4:00 p.m. The AD said she used to be a server and she knew not to pick up a glass from the top around the mouthpiece. She said staff should perform hand hygiene between handling glassware. The AD said activities staff participated in serving drinks to residents during activities and meal times. She said because activities staff offered drinks to residents during activities, the staff were trained on hand hygiene and the new activities staff typically shadowed her for two weeks of initial training. The staff's initial training did include hand hygiene and resident hydration. II. Ensure staff washed hands and changed single use gloves appropriately while plating and serving resident meals A. Professional reference The Colorado Retail Food Regulations, effective [DATE], were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. The regulations read in pertinent part, Food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink. Food employees shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: rinse under clean, running warm water; apply an amount of cleaning compound recommended by the cleaning compound manufacturer; rub together vigorously for at least 10 to 15 seconds while paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers; thoroughly rinse under clean, running warm water; immediately follow the cleaning procedure with thorough drying using a method. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; when switching between working with raw food and working with ready-to-eat food; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. B. Facility policy and procedure The Hand Hygiene Procedure guideline, undated, was provided by QM #1 on [DATE] at 4:45 p.m. The guideline revealed in pertinent part, To wash hands, turn the faucet on, or push the knee pedals laterally, or press the pedals with your foot to regulate the flow and temperature of the water. Avoid splashing water against your uniform. Regulate the flow of water so that the temperature is warm. Wet your hands and wrists thoroughly under the running water. Apply three to five milliliters (ml) of antiseptic soap, and rub your hands together. Wash your hands, using plenty of lather and friction, for at least 15 to 30 seconds. Interlace your fingers and rub your palms, including around the thumb area and the back of your hands, with a circular motion at least five times each. Keep your fingertips pointed down to facilitate the removal of microorganisms. Areas underlying the fingernails are often soiled. Clean them with the fingernails of the other hand, using additional soap or a disposable nail cleaner. Rinse your hands and wrists thoroughly, keeping your hands down and your elbows up. Dry your hands thoroughly, from the fingers to the wrists, with a paper towel, a single-use cloth, or a warm-air dryer. If you use a paper towel, discard it in the proper receptacle. To turn off the hand faucet, use a clean, dry paper towel, making sure to avoid touching the faucet handles with your hands. Turn off the water with a foot or knee pedal if applicable. C. Observations A kitchen walkthrough was conducted on [DATE] at 9:10 a.m. During the walk through, an unidentified dietary aide picked up a room delivery plate cover from the floor while wearing single use gloves and took the plate cover to the dirty side of the dish room. -The dietary aide did not wash his hands or don new gloves before returning to the clean side of the dish machine room and proceeding to put away clean dishes. The dinner meal service was observed on [DATE] during a continuous observation beginning at 4:00 p.m. and ending at 5:35 p.m. -During the meal service, kitchen staff did not perform hand hygiene correctly while prepping and plating resident meals. -At 4:21 p.m. cook (CK) #1 said he was wrapping plates with plastic wrap, wearing single use disposable gloves. CK #1 stopped wrapping the desserts, discarded his gloves in the trash receptacle and donned new single use disposable gloves without washing his hands. (continued on next page)

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	065221	A. Building B. Wing	04/02/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 4:23 p.m.,while wearing gloves, CK#1 moved the box of plastic wrap on the table, removed a towel from the sanitizer bucket and wiped down the prep table. He placed the sanitizer towel back in the bucket and discarded his single use gloves in the trash receptacle. CK #1 washed his hands, scrubbing with soap and water for only four seconds before drying his hands and turning off the water. -At 4:25 p.m. CK #1 turned off the oven timer and placed a digital food thermometer in a prep table drawer. He walked to the back of the kitchen and washed his hands, scrubbing with soap and water for only four seconds before drying his hands and turning off the water. -At 4:44 p.m. CK #1 removed his single use gloves and discarded them in the trash receptacle. He walked to the back of the kitchen and washed his hands, scrubbing with soap and water for only four seconds before drying his hands and turning off the water. -At 4:48 p.m. CK #1 was cooking at the stove top. He removed and discarded his single use gloves in the trash receptacle. He walked to the back of the kitchen and washed his hands, scrubbing with soap and water for only six seconds before drying his hands and turning off the water. -CK #1 donned a new pair of single use gloves and went back to the stove and used a metal spatula [NAME] that had been used throughout service to lift a cooked hamburger patty from the sautee pan and placed the burger on a bun. CK #1 used the same right gloved hand he used to turn the spatula to put the top of the hamburger bun on the patty. -CK #1 failed to use a utensil or wash his hands and don a new single use glove to place the top of the bun on the hamburger patty. -At 4:57 p.m. CK #1 placed a six inch deep half size steam table pan of baked potatoes on the hot food holding line while wearing single use gloves. CK #1 used the same gloved hands to put the baked potatoes into a new pan on the steam table. The potatoes were served to residents for dinner. -At 5:15 p.m. CK #1 removed his single use gloves and discarded them in a trash receptacle. CK #1 put a single use glove on his right hand. -CK #1 failed to wash his hands in between donning new gloves. D. Staff interviews The dietary manager (DM) and the nursing home administrator (NHA) were interviewed on [DATE] at 1:35 p. m. The DM said he worked on handwashing with the dining staff almost daily and as much as possible. The DM said he made CK#1 aware his hand washing was incorrect during and after dinner service on [DATE]. He said he provided a verbal hand washing in-service for kitchen staff on [DATE]. The DM said CK#1 did not know proper hand hygiene on [DATE] but that had been corrected. The DM said all the staff had a hand hygiene video in-service included in their initial training before starting work and staff were provided additional ongoing hand hygiene in-services. The DM said he would follow through and ensure staff knew how and when to properly wash their hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said if the infection preventionist (IP) provided hand washing training to staff, the IP told staff to sing the happy birthday song while staff washed their hands so the process was completed in the proper amount of time. III. Ensure food was labeled and dated and disposed of timely in one of two nourishment rooms A. Professional reference The Colorado Retail Food Regulations, effective [DATE], were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. The regulations read in pertinent part, Refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations.The day the original container is opened in the food establishment shall be counted as day one; and the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. B. Facility policy and procedure The Food From Outside Sources policy, dated [DATE], was provided by the director of nursing (DON) on [DATE] at 1:53 p.m. The policy revealed in pertinent part, This policy defines use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption. Shelf stable foods shall be wrapped, dated with opening, name and labeled unless for immediate consumption. If food is not consumed upon arrival, it may be stored in a suitable container and labeled with the date, resident name and item description if needed. Restaurant leftovers need to be labeled with the date, name and consumed within 24 hours. Resident food stored under refrigeration shall have a name, date and expiration on the label. Perishable food is discarded within three days from any resident refrigerators unless the food item is safe until a printed expiration date. Resident food which is shelf stable is marked with the name and date of opening and discarded by the expiration or best by date. The facility reserves the right to discard any foods which are not correctly labeled, dated or of questionable content or source to assure safety for all residents. C. Observations On [DATE] a posted sign in the nourishment room documented, Refrigerators are for resident use only. All items must be dated and labeled. Any items that do not have a label and expiration date will be exposed of daily. On [DATE] at 2:40 p.m. the following items were observed inside the nourishment refrigerator and freezer for hallways 500, 600 and 700: -12 four ounce health shake cartons. Each carton had the directions printed on the side store frozen and thaw for 14 days. There were no pull dates or expiration dates written on the health shake cartons. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A clear plastic container with a blue lid that contained a meat product. A printed date on the container had a use by date of [DATE]. There was no resident's name, food item name received date on the container. -An unidentified item wrapped in foil with a resident's last name and room number. There was no food item name, received or expiration date written on the product. -A bag of [NAME] assorted truffles in the freezer with no name or date of any kind. -A clear freezer bag of five tamales with no name, date or label of any kind written on the bag. -A clear freezer bag and a small clear trash bag, both contained items wrapped in foil, labeled with a residents name and room number, however there was no date or item name on either bag. -A clear plastic trash bag with items wrapped in foil inside the bag in the freezer. The bag had a resident's name and room number written on the bag but no expiration date. On [DATE] at 12:00 p.m. the following items were observed inside the nourishment refrigerator and freezer for hallways 500, 600 and 700: -Eight four ounce health shake cartons. Each carton had the directions printed on the side store frozen and thaw for 14 days. There were no pull or expiration dates written on the health shake cartons. -A clear plastic container with a blue lid that contained a meat product. A printed date on the container had a use by date of [DATE]. There was no resident's name, food item name received date on the container. -An unidentified item wrapped in foil with a resident's last name and room number. There was no food item name, received or expiration date written on the product. -A clear freezer bag and a small clear trash bag, both contained items wrapped in foil, labeled with a residents name and room number, however there was no date or item name on either bag. -A clear plastic trash bag with items wrapped in foil inside the bag in the freezer. The bag had a resident's name and room number written on the bag but no expiration date. On [DATE] at 9:00 a.m. the following items were observed inside the nourishment refrigerator and freezer for hallways 500, 600 and 700: -An unidentified item wrapped in foil with a resident's last name and room number. There was no food item name, received or expiration date written on the product. -An open 20 ounce bottle of ketchup, three fourths full with no name or expiration date. -A bottle of caramel macchiato creamer dated ,d+[DATE] with no name, and printed on the bottle was use within two weeks of opening or by the date on the bottle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A clear plastic container with a pink lid in the freezer with no label or date. -There was a commercially prepared protein lover's six ounce pizza with a printed expiration date of [DATE], and no name written on the box. -A clear freezer bag and a small clear trash bag, both contained items wrapped in foil, labeled with a residents name and room number, however there was no date or item name on either bag. -A clear plastic trash bag with items wrapped in foil inside the bag in the freezer. The bag had a resident's name and room number written on the bag but no expiration date. D. Staff interviews The DM, NHA and registered dietitian (RD) were interviewed on [DATE] at 1:35 p.m. The DM said the night cook stocked the nourishment refrigerators and should also discard expired food items. The NHA said nursing staff and whomever on the nursing staff accepted a resident food item should write a name on that food item. The NHA said food, such as leftovers, should not be kept more than three days in the refrigerator. The RD and the NHA said nourishment refrigerators were for resident food only and not for staff food. The DM said the staff member who stocked the nourishment refrigerator should date the health shakes, which staff should have known because the kitchen staff had a sign that stated to label the health shakes. IV. Ensure food items on meal trays were covered during transport in the hallway during meal delivery to resident rooms A. Facility policy and procedure The Infection Control Policy and Overview policy, revised [DATE], was provided by the director of nursing (DON) on [DATE] at 1:59 p.m. The policy revealed in pertinent part, All employees must be made aware of how they can play a part in preventing the spread of infection, including to implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination and properly store, handle, process, and transport (cover) linens/food to minimize possible contamination. Employees can be exposed to or expose residents to diseases through improper hand hygiene, improper glove use (for example, utilizing a single pair of gloves for multiple tasks or multiple residents) and improper food handling. B. Observations The following observations were made on [DATE] during dinner service on the 500, 600 and 700 hallways. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The cart that contained resident dinner meals was delivered to the nurses station at 5:38 p.m. During meal delivery, the resident dinner meal trays were removed from the meal cart and carried from the nurses station down the hallways to resident rooms by nursing staff. The meals were observed to have six inch dessert plates and a square blondie dessert bar on the plate. -A clear plastic lid was placed on the dessert plates but only partially covered the desserts at an angle, leaving two sides in a top portion of the dessert exposed as the meal trays were carried down the hallways to residents' rooms. -The facility failed to cover the desserts entirely before delivering the meal trays down the hallway to resident rooms. Resident meal trays were delivered to resident rooms on all three halls at the following times: At 5:41 a meal tray that contained a partially covered dessert was delivered; At 5:42 three meal trays containing partially covered desserts were delivered; At 5:44 a meal tray that contained a partially covered dessert was delivered; At 5:45 a meal tray that contained a partially covered dessert was delivered; At 5:46 a meal tray that contained a partially covered dessert was delivered; At 5:47 a meal tray that contained a partially covered dessert was delivered; At 5:48 a meal tray that contained a partially covered dessert was delivered; and, At 5:49 a meal tray that contained a partially covered dessert was delivered. C. Staff interviews CNA #4 was interviewed on [DATE] at 4:35 p.m. CNA #4 said food had to be completely covered for meal trays transported through the hallways to residents' rooms. CNA #4 said she had received training but was unsure what training was like for newer staff at the facility. The DM and NHA were interviewed on [DATE] at 1:35 p.m. The DM said he was not aware the desserts were not entirely covered for dinner service on [DATE]. The NHA said meal delivery for trays carried down a hallway required food to be completely covered.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48458 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the laundry area was free from multiple environmental concerns. Findings include: I. Facility policy The Submitting a Maintenance Request form was provided by quality mentor (QM) #1 on 4/2/24 at 3:13 p.m. It read in pertinent part: Maintenance requests need to be submitted. Fill out and submit the work order. Instructions for completing the work order were on the form. -A policy regarding the protocol for environmental issues within the facility was not provided by the end of the survey on 4/2/24. I. Observations and interview On 4/2/24 at 9:45 a.m. and 10:30 a.m., the facility's laundry area was observed with the environmental services director (ESD). The following concerns were observed: -The exhaust fan in the soiled linen room was not on. The fan's cover was off and wires were hanging out of the fan box. The ESD said she did not know how long the fan had been broken. -Unfinished sheet rock and a hole in the ceiling were present in the sorting room. In the laundry room (with washers, dryers, and folding table) the following were observed: -Chipped paint on the ceiling above a dryer; -Unfinished sheet rock with patched areas above the clean linen cart; -A fluorescent light cover was attached to the ceiling on one side. The other side of the four foot long cover was hanging down on top of a dryer and there was lint noted inside of the light cover; -There were five holes in the ceiling and two holes in the walls of the laundry room; and,. -Lint was present behind dryers and on the walls in the laundry room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ESD said she was not aware any of the items needed repair/maintenance and said she would notify the maintenance supervisor (MS). II. Staff interview The MS was interviewed on 4/2/24 at 11:10 a.m. The MS said there were no open work orders for the laundry area. He observed the exhaust vent in the soiled linen room. He tested the fan and said it did not work. The MS said an exhaust fan was required and the fan needed to be replaced. He said he was going to replace the fan. The MS said he had never been in the soiled linen area before. The MS said he had not noticed the wall and ceiling findings in the laundry room and he said all of the environmental concerns observed needed repair. The MS said the holes in the walls and the lint created a fire safety hazard.