STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065223	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley Manor Care Center	735 S Locust St Denver, CO 80224

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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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the upstairs kitchen. Specifically, the facility failed to:-Ensure dietary staff performed appropriate hand hygiene during meal service; and,-Ensure the rims of cups were not touched by staff when serving beverages. Findings include:I. Failed to ensure dietary staff performed appropriate hand hygiene during meal serviceA. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, were retrieved on 3/3/26. It revealed in pertinent part, 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 touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; 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; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. Facility policy and procedureThe Hand Hygiene policy and procedure, revised 10/28/25, was provided by the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, The facility has adopted the CDC's (Centers For Disease Control And Prevention) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings for indications for hand hygiene that are generally consistent with the World Health Organization's 5 (five) moments for hand hygiene. Unless hands are visibly soiled, an alcohol-based hand rub (ABHR) is preferred over soap and water in most clinical situations. Associates perform hand hygiene (even if gloves are used) in the following situations:before and after contact with the resident; after contact with blood, body fluids, or visibly contaminated surfaces; after contact with objects and surfaces in the resident's environment; after removing personal protective equipment (gloves, gown, eye protection, facemask). Staff should wash hands with soap and water under the following situations as ABHR is not appropriate in these circumstances: before eating; after using a restroom; when their hands are visibly soiled (blood, body fluids); after caring for a resident with known or suspected C-difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high.C. ObservationsDuring a continuous observation on 2/24/26, beginning at 4:45 p.m. and ending at 6:19 p.m., the following was observed during the dinner meal service in the upstairs kitchen:At 4:45 p.m. dietary aide (DA) #1 entered the kitchen pushing the insulated food cart and immediately began unloading the food into the steam table. -DA #1 did not perform hand hygiene prior to unloading the food from the food cart into the steam table. At 4:53 p.m. DA #1 calibrated the food temperature thermometer and began uncovering the food. -DA #1 did not perform hand hygiene after calibrating the food temperature thermometer and prior to uncovering the food. At 4:55 p.m. DA #2 entered the upstairs kitchen area. DA #2 took over taking the temperatures of the food for DA #1 so DA #1 could go use the bathroom.-DA #2 did not perform hand hygiene upon entering the kitchen or prior to taking the temperature of the food. At 4:58 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	p.m. DA #1 came back from the bathroom. -DA #1 did not perform hand hygiene upon entering the kitchen. -At 4:59 p.m. DA #1 answered the telephone but did not perform hand hygiene afterwards. At 5:01 p.m. DA #2 moved the large trashcan by touching the lid, opened her energy drink and took a drink. -DA #2 did not perform hand hygiene after touching the lid of the trashcan and taking a drink of her energy drink. At 5:11 p.m. DA #1 washed her hands and then proceeded to touch her face. -DA #1 did not perform hand hygiene again after touching her face. At 5:12 p.m. DA #2 took the evening meal menu that was taped to the wall and hung it over the steam table where the uncovered food was on the serving line. -DA #2 did not perform hand hygiene after removing the evening menu from the wall and hanging it over the steam table. At 5:17 p.m. DA #2 answered the telephone but did not perform hand hygiene afterwards. At 5:20 p.m. DA #1 and DA #2 were told to stop serving because the mixed salad was not down to the correct temperature. At 5:37 p.m. DA #1 put her hands in her pockets and then touched her face. -DA #1 did not perform hand hygiene after putting her hands in her pockets and touching her face. -At 5:45 p.m. DA #1 and DA #2 were able to start serving again, however, neither DA #1 or DA #2 performed hand hygiene prior to resuming meal service. At 5:55 p.m. DA #1 answered the telephone, scratched the back of her neck and required prompting to perform hand hygiene afterwards. At 5:56 p.m. DA #1 finished washing her hands and then brought the paper towel that she had used to dry her hands and set it on the serving table while she waited for more sandwiches to be delivered. -At 5:58 p.m. DA #2 rested her forehead and forearms on the serving table while waiting for sandwiches to be delivered and did not sanitize her hands or the serving table afterwards. At 6:01 p.m. the upstairs kitchen ran out of plates and were still waiting on more sandwiches to be delivered. At 6:02 p.m. DA #1 and DA #2 began to load the food cart with dirty dishes while waiting for the plates and sandwiches. DA #2 touched her face and touched the beanie that she was wearing. DA #2 did not perform hand hygiene after touching her face and her beanie. At 6:03 p.m. The additional sandwiches were delivered to the upstairs kitchen.At 6:04 p.m. DA #1 and DA #2 were still loading the dirty dishes onto the cart when the additional plates were delivered. DA #1 and DA #2 resumed plating room trays for residents. -DA #1 and DA #2 did not perform hand hygiene after handling the dirty dishes and prior to resuming plating room trays. At 6:07 p.m. DA #2 leaned her forearms and forehead on the serving table and touched her face and hat.-DA #2 did not perform hand hygiene or sanitize the serving table. At 6:08 p.m. the registered dietitian (RD) sent DA #2 downstairs to the main kitchen and helped DA #1 finish plating the room trays. DA #1 began placing a small pile of used gloves and paper towels on the serving table while food was still being served. -The RD did not instruct DA #1 to remove the soiled gloves and paper towels from the serving table.-At 6:19 p.m. the last room tray was served and the pile of used gloves and paper towels was still sitting on the serving table. II. Failed to ensure the rims of cups were not touched by staff when serving beverages A. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 3/3/26. It revealed 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. (4-904.11)B. Observations On 2/23/26 at 11:38 a.m. an unidentified staff member delivered a beverage to a female resident while holding the rim of the cup. On 2/23/26 at approximately 11:56 a.m. an unidentified staff member moved drinks on the table around by the rims of the cups so she could put the plates down for the residents. On 2/23/26 at approximately 11:58 a.m. another unidentified staff member was serving drinks to a resident by holding the rim of the cup. On 2/23/26 at 12:06 p.m. an unidentified staff member was moving drinks around by the rim of the cups getting them ready for room trays. III. Staff interviewsDA #3 was interviewed on 2/25/26 at 3:21 p.m. DA #3 said employees should wash their hands anytime they came into contact with a resident, handled anything that was raw or soiled and after they were finished pushing a cart. He said that staff should never touch the rim of a cup when they were serving beverages to residents. [NAME] (CK) #1 was interviewed on 2/25/26 at 3:25 p.m. CK #1 said employees should wash their hands all the time. He said hand hygiene should be performed whenever dietary switched tasks, came back to the kitchen (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	after using the bathroom, when they were prepping food, after they touched their face and when they took their gloves off. The dietary manager (DM) was interviewed on 2/26/26 at 2:23 p.m. The DM said dietary staff should be washing their hands anytime they entered the kitchen, when they switched their gloves, when they went from touching dirty dishes to touching clean dishes, after touching their faces, when leaving the serving line and after touching the garbage bin. She said staff should not be touching the rims of cups or glasses when they were serving drinks to residents.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to meet all requirements for the provision of hospice care for three (#3, #58 and #33) of three residents reviewed for hospice services out of 41 sample residents. Specifically, the facility failed to ensure hospice notes were readily accessible and the comprehensive care plan was developed with delineation of care responsibilities established between the facility and hospice for Resident #3, Resident #58 and Resident #33.Findings include: I. Facility policy and procedure The Hospice policy and procedure, revised 9/3/25, was provided by the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part The facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the long-term care (LTC) facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility must designate a member of the interdisciplinary team (IDT) to ensure hospice representatives are oriented to the facility and that the resident receives quality care in collaboration with the facility staff and the hospice staff. The designated IDT member facilitates communication between the facility and hospice and includes the resident's representative in decision-making. II. Resident #3 A. Resident status Resident #3, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic systolic congestive heart failure (when the left ventricle weakens and cannot contract properly, reducing blood flow to the body and backing up fluids to the lungs), hypertensive heart disease with heart failure, dementia and chronic respiratory failure with hypoxia (low levels of oxygen in the blood). The 12/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The assessment revealed she was dependent on staff for most of her activities of daily living (ADL) and mobility. The assessment indicated the resident was receiving hospice care services. B. Record review The February 2026 CPO documented Resident #3 was admitted to hospice care services on 9/2/25. -A review of the comprehensive care plan, initiated 9/12/25, revealed Resident #3 was receiving hospice care services, however it failed to include delineation of care responsibilities between the facility and hospice care services. A review of Resident #3's electronic medical record (EMR) revealed documentation of hospice (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recertifications for the resident and a hospice plan of care. -However, review of the resident's EMR failed to reveal documentation of routine hospice care visits provided to the resident. III. Resident #58 A. Resident status Resident #58, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnoses included chronic respiratory failure, pulmonary hypertension and anxiety disorder. The 2/13/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment f revealed that Resident #58 needed substantial to maximal assistance with most of her ADLs. The MDS assessment did not indicate Resident #58 was receiving hospice care services. -However, the resident was admitted to the facility for respite care and was receiving hospice care services at home and at the facility (see record review below). B. Record review Review of Resident #58's EMR revealed she was receiving hospice care services upon her admission to the facility on 2/8/26. Review of her EMR revealed she was at the facility for respite care. A review of Resident #58's comprehensive care plan, initiated 2/9/26, revealed her hospice care plan was initiated on 2/24/26 (during the survey process), 16 days after her admission to the facility. Resident #58's hospice care plan failed to include a delineation of care responsibilities between the facility and hospice care services. IV. Resident #33 A. Resident status Resident #33, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included chronic obstructive pulmonary disease (a progressive, incurable lung disease primarily caused by smoking that restricts airflow, causing chronic shortness of breath, wheezing, and phlegm-producing coughs), depressive disorder, and chronic kidney disease (the long-term, progressive loss of kidney function, commonly caused by diabetes and high blood pressure). The 3/5/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required supervision for personal hygiene and dressing. The MDS assessment did not indicate the resident was receiving hospice services. B. Record review (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The February 2026 CPO identified resident #33 was admitted to hospice services on 4/1/25. A review of the comprehensive care plan, revised 4/16/25, revealed Resident #33 was receiving hospice care services, however, the care plan failed to include detailed interventions and a delineation of care services between the facility and the hospice care services company. A review of Resident #33's electronic medical record (EMR) revealed there were hospice notes uploaded on 4/22/25. -However, there were no other hospice notes uploaded in the resident's EMR until 2/25/26, during the survey. V. Staff interviews The hospice nurse practitioner (NP) was interviewed on 2/26/26 at 9:00 a.m. The hospice NP said hospice care staff would document in a binder when they visited a resident. She said the hospice staff would chart clinical documentation in their own electronic system, not the facility's. She said the hospice staff would document the physician's order changes in the facility binder, but they would additionally fax over the physician's orders to the facility. The hospice NP said from her understanding, the hospice company would fax over their clinical documentation weekly to the facility. LPN #4 was interviewed on 2/26/26 at 9:45 a.m. LPN #4 said each nurses' station had a hospice binder which was individual to each resident. She said the hospice binder told staff when hospice came to visit and told CNAs whether or not the resident got a shower. She said when hospice staff were inside the facility, they would give a quick report to nursing staff and would check with nurses before seeing the residents. LPN #4 said reports from hospice staff often described what medications residents were getting, whether or not the resident would receive a shower, and any other pertinent updates. LPN #4 was unsure whether or not there were full assessments located in the hospice binders. LPN #4 said staff could additionally look in the residents' EMRs, under the progress notes and the documents tab to view hospice notes. She said the hospice notes would tell staff what care was given to the hospice resident on each specific visit and whether or not there were any changes in condition. LPN #4 said it was important to see hospice notes in order to know what was going on with the residents and to provide appropriate care. She said it would be important to know whether or not a hospice resident had a change of condition or had increased pain. LPN #4 said medical records uploaded hospice documentation from the binders into the residents' EMRs. She said she assumed that each hospice company sent notes to social services or medical records and the notes were uploaded as they were received. Licensed practical nurse (LPN) #2 was interviewed on 2/26/26 at 9:51 a.m. LPN #2 said the facility had a binder that hospice staff would write in when they came to visit a resident. She said the hospice certified nurse aides (CNA) would document if they gave the resident a shower. She said most of the communication with hospice was done verbally. The social services director (SSD) was interviewed on 2/26/26 at 6:14 p.m. The SSD said she would (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	create the hospice baseline care plan if a resident was admitted to the facility on hospice. She said she would also create the care plan for hospice care services when a resident was already a resident in the facility. She said a baseline care plan should be completed within 48 hours of admission. She said Resident #58's baseline care plan was not completed timely. She said it was important to have the baseline care plan completed timely because if something were to happen or change, staff would know who to inform for care coordination. The medical records director was interviewed on 2/26/26 at 6:58 p.m. The medical records director said he started working for the facility at the end of June 2025 or beginning of July 2025. He said his first priority when a resident was receiving hospice care services was getting records uploaded and making sure the documents were signed and completed before they were scanned into the EMR. He said the hospice care services companies would email him residents' records or the records that he requested from the hospice care services companies. He said the hospice care services companies would email him the residents' clinical documentation from their visits every week. He said if the hospice care services company did not email him residents' records, he would request the records from them. He said the records that they sent to him were the residents' progress notes, physicians' orders, care plans and anything that hospice might find important for the facility to know. -However, there was no clinical documentation found in the resident's EMRs during the survey (see record review above). The medical records director said he had recently found out that Resident #3 was receiving hospice care services. He said he found out about a week and a half prior to the survey. He said he had no knowledge or contact with Resident #3's hospice care services contact prior to a week and a half ago. He said he had to ask the admissions staff for all the residents receiving hospice care services. He said he was unsure of who was responsible for informing him if a resident was admitted to hospice care services. He said from a medical records standpoint, Resident #3's EMR was incomplete due to none of her hospice progress notes being uploaded. He said it was important to have her hospice notes uploaded because any hole in the record could cause delay in care or a lack of care for the resident. The medical records director said for Resident #33, he was not sure how often he received notes from the hospice care services company for him. The medical records director said he asked for the hospice services company's certification and when he received the certification, he also received the hospice notes for Resident #33 (during the survey). The director of nursing (DON) and the regional clinical resource were interviewed together on 2/26/26 at 7:25 p.m. The DON and the regional clinical resource said the facility and the hospice care services team communicated using the binder that was at the nurses' station. The DON and the regional clinical resource said that hospice staff would write in the binder describing what services were provided during a visit for each resident. The DON and the regional clinical resource said that the hospice care services companies would send the facility the resident's clinical documentation, and the medical records director would upload the documentation into the EMR. The regional clinical resource said the residents' hospice care plans should have a delineation of responsibilities between the facility and hospice. She said it was important to have a delineation of responsibilities so both the facility and the hospice care team would know who was providing what service for residents in order to provide the best care for the residents. The regional clinical resource said there should be clinical documentation from hospice in the residents' EMRs so facility staff knew (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what was being provided at each hospice and so the facility staff and the hospice care staff were on the same page.

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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, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.Specifically, the facility failed to:-Ensure housekeeping staff cleaned and disinfected residents' rooms in a hygienic manner; -Ensure housekeeping staff performed appropriate hand hygiene while cleaning residents' rooms; -Ensure a urine spill in the dining room was cleaned and disinfected in an appropriate manner; and,-Ensure urinary catheter bags were stored in a sanitary manner in residents' rooms.Findings include:I. Failed to ensure housekeeping staff cleaned and disinfected residents' rooms in a hygienic manner and performed appropriate hand hygiene while cleaning residents' roomsA. Professional referenceThe Centers for Disease Control and Prevention's (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 3/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.The CDC/ Environment Cleaning Procedures (revised 3/19/24) was retrieved on 3/2/26 from https://www.cdc.gove/healthcare-associated-infections/hcp/cleaning-global/supplies-and-equipment.html#cdc_ read in pertinent part, Best practices for glove usage for cleaning: perform hand hygiene immediately before putting on gloves and directly after taking them off. When use of gloves is indicated, always change them between each cleaning session (routine cleaning of a patient zone under contact precautions, terminal cleaning of a general patient area).B. Facility policy and procedureThe Hand Hygiene policy, revised 10/28/25, was received from the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, Staff must perform hand hygiene (even if gloves are used) in the following situations: before and after contact with the resident; after contact with blood, body fluids, or visibly contaminated surfaces and. after contact with objects and surfaces in the resident's environment. C. Room cleaning observationsOn 2/25/26 at 8:54 a.m. housekeeper (HK) #1 was observed cleaning resident room [ROOM NUMBER], a double occupancy room. HK #1 performed hand hygiene with alcohol based hand rub (ABHR) and applied clean gloves. HK #1 collected a disinfectant spray bottle labeled from the housekeeping cart, entered the resident's room, went to the residents' bathroom and sprayed the toilet (both inside and out) and the wall grab bars. HK #1 began dusting in the residents' room. HK #1 started above the main entry door and worked counterclockwise through the room, dusting the dresser, the light fixtures above the sink area, the bathroom ceiling areas, the top of the inside and outside of the bathroom door, the window blinds, over the second resident's bed area, including the light fixtures and art work on the wall, over the curtain pull area, then over the first resident's bed, including her light fixtures and decor that was hanging. HK #1 finished her dusting above the oxygen concentrator by the main entry door to the room. HK #1 then proceeded to perform hand hygiene with ABHR, don a new pair of gloves and take a premoistened washcloth to wipe down the areas in the residents' room. She used the same cloth for both sides of the room.-HK #1 failed to use a different dusting device or cloth for each side of the residents' room. -Additionally, HK #1 continued to dust in the residents' living space after using the dusting device to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dust in the residents' bathroom. At 9:13 a.m., HK #1 went to the housekeeping cart, performed hand hygiene, applied clean gloves and took the toilet brush and container from the cart. HK #1 went to the residents' bathroom and used the toilet brush to clean in and around the toilet bowl and toilet tank, including the surface of the toilet tank that was housed on the floor. Approximately one minute after cleaning all the toilet surfaces, she put the brush back into the toilet bowl, flushed the toilet and then tapped the toilet brush against the toilet seat. Droplets spread from the toilet brush onto the bathroom walls and floor. She shook the toilet brush five times and then put the brush back into the container. She took a rag and wiped down the surfaces of the toilet seat, the toilet tank and handrails and flushed the toilet again. -HK #1 failed to clean the toilet from cleanest to dirtiest areas when she used the toilet brush on the surfaces outside of the toilet bowl. -Additionally, when HK #1 hit the brush against the toilet seat to clear the excess solution and contaminated water from the brush, the droplets from the brush spread onto the bathroom walls resulting in cross contamination and the spread of germs.HK #1 went back to the housekeeping cart, put the toilet brush container into the cart and placed the used rag into a soiled bucket. She then removed her gloves, performed hand hygiene, and applied a new pair of gloves. She went back into the residents' room to mop. HK #1 completed cleaning the residents' room at 9:24 a.m.On 2/25/26 at 9:58 a.m. HK #2 placed her housekeeping cart outside room [ROOM NUMBER] and performed hand hygiene at the cart with ABHB. She applied a clean pair of gloves prior to entering the resident room. She collected a disinfectant spray bottle from the housekeeping cart and went into the resident's bathroom to spray down the toilet area including the toilet bowl, the toilet tank and under the toilet seat. She then closed the bathroom door, set a timer for ten minutes on a cellular phone and took the bottle of disinfectant back to the housekeeping cart.-HK #2 failed to change her gloves and perform hand hygiene after spraying the toilet with disinfectant and touching the lid of the toilet.Using the same gloves she used when touching the toilet lid, HK #2 took a dusting device out of her cart and proceeded to dust the top of the lighting fixture over the sink, the top of the bathroom door, the blinds and the radiator vents on the floor. She dusted the resident's doorway last before putting the dusting device back on the cart. -HK #2 did not change her gloves or perform hand hygiene after returning the dusting device to her cart.Using her same soiled gloves, HK #2 took a cleaning rag out of a container that was premoistened with a disinfectant solution. She went back into the resident's room and wiped the mirror and sink area, moving any personal items out of the way and then returning them when finished.-HK #2 did not change her gloves or perform hand hygiene prior to obtaining a cleaning rag out of the disinfectant solution and touching the resident's personal items. Without changing her gloves and using the same cleaning rag, HK #2 proceeded to wipe down the resident's bedside tray table surface, the bottom of the tray table area, the nightstand, again moving the resident's personal items out of the way to wipe underneath and then replacing them in their original spot, and finished with using the rag to clean the resident's dresser top. When she finished with the surface cleaning, HK #2 took the trash bag out of the trash container, disposed of it in the housekeeping cart and replaced the bag in the container. Without changing her gloves, HK #2 proceeded to sweep the resident's room, including the bathroom area, and gathered all the debris into her dust bin. The timer went off on the phone.-HK #2 failed to change her gloves or perform hand hygiene after removing the trash from the resident's room and prior to using the broom to sweep the resident's room and bathroom.HK#2 returned the broom and dustbin to the cart and took another premoistened rag from the cart and the toilet brush container. -HK #2 again failed to change her gloves or perform hand hygiene prior to obtaining another cleaning rag from the container of disinfectant solution.HK #2 returned to the resident's bathroom where she cleaned the toilet from top to bottom with the rag, including the top of the toilet tank, the toilet tank, the sides of the toilet tank, the flush handle, the underside of the toilet bowl and then the bottom area on the floor surface. She used the toilet brush to scrub under the toilet bowl rim and the toilet bowl. She flushed the toilet and squeezed the excess water from the scrub brush into the toilet tank. She then put the brush back into the container and took the rag and the container back to the cart.-HK #2 failed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change her gloves and perform hand hygiene after cleaning the toilet, which included squeezing the excess water from the soiled toilet scrub brush with her gloved hands. Wearing the same soiled gloves she had been wearing for the entire room cleaning observation, HK#2 took another premoistened rag from the disinfectant solution and went back into the resident's room. She began cleaning all the high contact areas, starting in the room first and then in the bathroom. She wiped the light switch, the bed remote, the call light, the mirror light switch, then the doorknobs to the bathroom, the hand rails in the bathroom, the emergency call light cord in the bathroom and then lastly the inside door knob of the bathroom door. She returned the rag to the dirty container and then took the mop handle from her cart. She opened a black storage container that was filled with a solution and had mop heads inside. Using her same soiled gloves, she picked up a mop pad, squeezed the excess water solution mix back into the container of solution where she retrieved it from and then attached the mop pad to her mop. -HK #2 failed to change her gloves and perform hand hygiene after cleaning the high contact surfaces in the resident's room and prior to obtaining the mop pad from the cleaning solution and squeezing the excess water from the mop pad back into the cleaning solution with her soiled gloves.HK#2 went to the resident's bathroom and mopped all areas behind and around the toilet bowl and then the floor, stopping at the bathroom/bedroom line. She took the used mop head pad to the cart, placed it in the dirty container and took out another clean mop head with her same soiled gloves. She followed the aforementioned procedure of squeezing the excess water back into the clean container. HK #2 finished mopping the resident's room, getting underneath the bed, underneath the night stand, under the sink area, and all along the floor surface of the area. She mopped backwards towards the resident's room door, where the last task she did was take another premoistened rag and wiped the doorknobs for the main door. She put the dirty rag into the dirty container, removed the dirty mop head, placed it in the same dirty container and then took off her gloves and performed hand hygiene. HK #2 completed cleaning the resident's room at 10:15 a.m.-HK #2 failed to change her gloves and perform hand hygiene throughout the entire room cleaning observation, cleaning the resident's entire room and bathroom with the same pair of soiled gloves throughout the process.HK #2 was observed a second time on 2/25/26 at 11:10 a.m., cleaning room [ROOM NUMBER]. HK #2 rolled the housekeeping cart to outside room [ROOM NUMBER] and performed hand hygiene at the cart with ABHR and applied a clean pair of gloves prior to entering the resident's room. HK #2 followed the same aforementioned process when cleaning room [ROOM NUMBER].-HK #2 failed to perform hand hygiene and change gloves after spraying down and touching the toilet seat, before and after cleaning high contact areas, before and after dusting, before and after taking the trash from the resident's room, before and after taking a new rag from the clean container, before taking a new mop head out of the solution container, before and after mopping and before cleaning high contact areas. -Additionally, HK #2 contaminated the clean mop bucket solution when excess water was squeezed from the mop pad with her soiled gloves. -HK #2 again failed to change her gloves and perform hand hygiene throughout the entire room cleaning observation, cleaning the resident's entire room and bathroom with the same pair of soiled gloves throughout the process D. Staff interviewsHK #1 was interviewed on 2/25/26 at 9:25 a.m. HK #1 said every resident room was cleaned daily in the same manner as she did during the observation (see observations above). The housekeeping supervisor (HKS) was interviewed on 2/26/26 at 1:45 p.m. The HKS said when new housekeeping staff were hired, he trained them personally on room cleaning. He said he created a housekeeping process sheet that was kept on each housekeeping cart, with one side written in Spanish and the other side written in English. He said it was his expectation that housekeepers followed that written cleaning process. The HKS said the dusting devices the facility used were not able to be disinfected, therefore housekeepers should not use them in residents' bathrooms. The HKS said he had specifically told staff the dusting devices were only to be used for room light fixtures and the window blinds. The HKS said he would set up a time to meet with management to discuss the purchase of disposable dusting devices.The HKS said housekeeping staff should be changing gloves at a minimum of three times (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during a room cleaning. The HKS said staff did not practice good infection control procedures when HK #1 hit the toilet brush against the toilet bowl and when HK #2 cleaned and completed an entire room cleaning with only one pair of gloves being used. He said staff would be trained specifically in infection control measures.II. Failed to ensure a urine spill in the dining room was cleaned and disinfected in an appropriate manner A. Professional referenceThe CDC's Environment Cleaning Procedures (revised 3/19/24) was retrieved on 3/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html#cdc_generic_secti It ready in pertinent part, For spills of blood or body fluids, wear appropriate personal protective equipment (PPE). Confine the spill and wipe it up immediately with absorbent (paper) towels, cloths, or absorbent granules (if available) that are spread over the spill to solidify the blood or body fluid (all should then be disposed as infectious waste). Clean thoroughly, using neutral detergent and warm water solution. Disinfect by using a facility-approved intermediate-level disinfectant.B. Facility policy and procedureThe Housekeeping Services policy, revised 1/6/226 was received from the NHA on 2/27/26 at 3:54 p.m. It read in pertinent part, Blood/Body Fluid Spills: If there is a blood or body fluid spill or contamination, clean and disinfect the area immediately in a two-step process. [NAME] off the spill area to prevent contact, as well as accidental slips and falls. Clean and disinfect the spill as soon as possible. Confine the spill and wipe it up immediately with absorbent paper towels, cloths or absorbent granules and dispose of it as infectious waste. Clean the area with a facility-approved cleanser. 1:10 dilution of bleach may be used. Disinfect using a facility-approved intermediate-level disinfectant.C. Dining room observation and staff interviewA continuous observation of the dining room on the second floor to the left of the nurses' station was conducted on 2/24/26, beginning at 4:00 p.m. and ending at 6:55 p.m At 5:25 p.m. Resident #23 was seated at the first table of the dining room with two other residents.At 5:40 p.m. a puddle was observed underneath Resident #23's wheelchair. A strong urine odor was noted and additional urine was trickling out from the back of the resident's wheelchair. At 5:51 p.m. more urine was observed puddling under Resident #23's wheelchair. At 6:30 p.m. an unidentified male certified nurse aide (CNA) came into the dining room pushing a different resident in a wheelchair. He wheeled the other resident's wheelchair right through the puddle of urine, causing urine wheel marks on the floor. At 6:31 p.m. an unidentified nurse came into the dining room with a soiled linen bag and put Resident #23's sweater and towels that she had been sitting on in her soiled wheelchair into the bag. A male CNA then wheeled Resident #23 through the puddle of urine again, leaving urine wheel marks down the hallway to Resident #23's room.At 6:41 p.m. a laundry assistant entered the dining room with a broom and a dust pan and started sweeping the dining room.At 6:48 p.m. the laundry assistant began mopping the far end of the dining room. He then proceeded to mop up the urine from the floor before he finished mopping the rest of the dining room with the same mop.The laundry assistant was interviewed on 2/24/26 at 6:55 p.m. The laundry assistant said he changed the mop water but did not change the mop head. He said he only cleaned the dining rooms with that specific mop head and did not clean bathrooms with it, so he did not have to change the mop head.-However, the laundry assistant did not change the mop head after mopping up Resident #23's urine from the floor and prior to finishing mopping the rest of the dining room. D. Additional staff interviewThe HKS was interviewed on 2/26/26 at 5:00 p.m. The HKS said he was not aware staff did not properly mop up Resident #23's urine in the dining room. He said the expectation was the laundry assistant would sweep and then mop. He said he could not confirm if the laundry assistant used a disinfectant solution on the floor. He said by the time dinner was over, he and the housekeeping staff were already gone for the day.The HKS acknowledged the use of disinfectant was pertinent to infection control and prevention. He said moving forward, he would ensure the laundry assistant had access to disinfectant floor solution and he would have his staff use a different mop head for each dining room.III. Failed to ensure urinary catheter bags were stored in a sanitary manner in residents' roomsA. Facility policy and procedureThe Indwelling Urinary Catheter (Foley) Management policy, revised 6/27/23, was received from the NHA on 2/27/26 at 3:54 p.m. It read in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pertinent part, Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. B. Urinary catheter observationOn 2/24/26 at 4:30 p.m. an interview was conducted in Resident #2's room. Observation during the interview revealed Resident #2 had her urinary catheter drainage bag hanging from the lower rail of the bed. The urinary catheter drainage bag was resting on the floor. On 2/25/26 at 8:17 a.m. a walk through observation revealed Resident #2's urinary catheter drainage bag hanging from the lower rail of the bed. The urinary catheter drainage bag was resting on the floor. C. Staff interviews CNA #1 was interviewed on 2/25/26 at 10:00 a.m. CNA #1 said urinary catheter drainage bags were emptied at least one time each shift, more if needed. She acknowledged urinary catheter drainage bags should never be touching the floor. At 10:14 a.m. CNA #1 observed Resident #2's urinary catheter drainage bag resting on the floor. CNA #1 immediately raised the resident's bed and adjusted the clip to bring the urinary catheter drainage bag off the floor. CNA #1 said the resident tended to lower her bed to the lowest position and that caused the urinary catheter drainage bag to hit the floor. CNA #1 said moving forward, the clip would be tighter so there wouldn't be any ability for the urinary catheter drainage bag to touch the floor. The director of nursing (DON) was interviewed on 2/25/26 at 6:15 p.m. The DON said her expectation was that all staff followed proper infection control policies and procedures. The DON said urinary catheter drainage bags should never touch the floor because of the high potential of contamination of germs. The DON said she was not aware that urinary catheter drainage bags were not being stored properly and she would use this as a learning experience and a good opportunity to provide staff with additional training related to urinary catheter drainage bags.

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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 provide the necessary services to maintain personal hygiene for one (#23) of four residents reviewed for services to maintain the highest practicable quality of life out of 41 sample residents.Specifically, the facility failed to ensure Resident #23 received timely incontinence care.Findings include:I. Facility policy and procedureThe Activities of Daily Living (ADL) policy, dated 9/4/24, was received from the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.II. Resident #23A. Resident statusResident #23, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included nondisplaced fracture of the body of the right calcaneus (a break in the right heel bone where the bone pieces remain in proper alignment), type 2 diabetes mellitus (chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency leading to high blood sugar), chronic kidney disease (long term irreversible loss of kidney function) and unspecified obesity.The 1/23/26 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. The resident was dependent upon staff to help with toilet transferring and toileting hygiene. The MDS assessment identified that Resident #23 was frequently incontinent of urine and bowel.B. Resident interviewResident #23 was interviewed on 2/23/26 at 3:19 p.m. Resident #23 said sometimes she did not receive help with toileting assistance on time. She said she had to wait a long time to get to the bathroom and sometimes she had accidents because she had to wait too long for help. Resident #23 said she asked staff to put two briefs on her so the urine would be contained. Resident #23 said sometimes even with two briefs, urine would leak through to the outside of her pants. She said leaking through the two briefs would happen often but it was worse at night time. Resident #23 said sometimes staff tried to bring her to the dining room when they knew she was wet. Resident #23 said staff brought her food to her bedroom instead and then changed her once they were done with everything in the dining room or before they went home. Resident #23 said that made her feel terrible and she said she felt desperate.C. Observations On 2/24/26 at 5:40 p.m. Resident #23 was in her wheelchair in the dining room next to an unidentified certified nurse aide (CNA). Resident #23 had liquid underneath her wheelchair. There was an odor of urine coming from the area underneath her wheelchair.At 6:12 p.m. Resident #23 came out of the dining room. She was pushing herself in her wheelchair down the hallway toward her room and had sizable amounts of urine dripping from behind her wheelchair.At 6:33 p.m. the resident had wheeled herself into her room. Urine was dripping from her wheelchair onto the tile floor.At 6:44 p.m. CNA #1 and CNA #2 entered Resident #23's room with the sit-to-stand mechanical lift. The CNAs hooked Resident #23's sling to the sit-to-stand lift and brought the resident up to a standing position from the wheelchair. CNA #2 said the resident's wheelchair cushion had urine on it. The CNAs assisted the resident to bring her pants down. The resident was observed to have two briefs on. There was a strong urine smell in the room. Both of Resident #23's briefs were saturated with urine and were heavy. The CNAs cleaned up Resident #23 and put cream on her perineal area. A fresh brief and a fresh gown were put on the resident. Before exiting the room, CNA #1 wiped up the urine off of the floor.D. Record reviewThe ADL care plan, revised 3/7/19, revealed Resident #23 was incontinent and needed assistance for toileting and hygiene. Pertinent interventions included assisting Resident #23 with toileting.The bowel and bladder care plan, revised 5/13/22, revealed Resident #23 was incontinent and needed assistance for toileting and hygiene. Pertinent interventions included assisting Resident #23 with toileting, utilizing spanish speaking CNAs whenever possible, implementing good personal hygiene following any incontinence episode, and providing perineal care, to include barrier cream for skin protection. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary incontinence care plan, revised 3/7/19, revealed Resident #23 was incontinent related to diabetes mellitus, chronic pain, opioids, and incontinence. The pertinent interventions included a prompted toileting program upon arising, before and after meals and before bed. An additional intervention for assisting Resident #23 with toileting and perineal care as needed was initiated on 1/26/22.-The care plan did not include interventions to educate the resident on limiting the number of briefs that should be worn to prevent skin breakdown. Review of Resident #23's progress notes did not reveal that Resident #11 requested to wear two briefs. The progress notes did not identify that Resident #11 refused to be cleaned or changed more frequently.III. Staff interviewsCNA #1 was interviewed on 2/24/26 at approximately 6:50 p.m. CNA #1 said Resident #23 was wet with urine. She said it was important for the resident to be dry because if the skin was not dry, it could break down. CNA #1 said Resident #23 had two briefs on that day (2/24/26) because the resident wanted to play bingo both on the first and second floor. CNA #1 said that on days when the resident wanted to play bingo, the staff put two briefs on her. CNA #1 said that Resident #23 attended bingo that day at 2:00 p.m.Licensed practical nurse (LPN) #3 was interviewed on 2/25/26 at approximately 2:30 p.m. LPN #3 said staff came onto shift at 2:00 p.m. LPN #3 said that at that time, staff were supposed to change Resident #23. She said the goal was to change Resident #23 before she went to the dining room. LPN #3 said most residents that were in wheelchairs were supposed to be checked to ensure they were clean and dry before going to the dining room. LPN #3 said they worked as a team to ensure Resident #23 was clean, but CNAs most often helped change the residents. LPN #3 said residents should not wear two briefs because it affected skin integrity and the staff tried to protect the residents' skin. LPN #3 said if a resident requested to wear two briefs, she expected the CNAs to educate the resident on why it was not a good idea. LPN #3 said if the resident requested to wear two briefs, she would document that in the progress notes. The director of nursing (DON) was interviewed on 2/26/26 at 7:23 p.m. The DON said nursing staff were supposed to provide incontinence care per facility protocol or every two hours and as needed. The DON said nursing staff should put only one brief on residents. She said facility protocol was to put one brief on residents and if a resident requested more than one, nursing staff should educate the resident on the risks of wearing more than one brief. The DON said risks to wearing two briefs would include skin breakdown, irritation, redness and being overly wet. The DON said nurses could educate residents on risks and CNAs could remind residents about risks. The DON said staff should be documenting if a resident was requesting to wear two briefs. She said it could be documented in the care plan, nursing progress notes or behavioral notes. The DON said the facility recently edited the care plan to reflect that Resident #23 was requesting two briefs and that this was sometimes a preference of hers. -However, the electronic medical record (EMR) did not not reflect that Resident #23 was requesting two briefs or that this was the preference of Resident #23 (see record review above).

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to clarify resuscitation choices and document them accurately in the medical records for two (#53 and #11) of two residents reviewed for advance directives out of 41 sample residents.Specifically the facility failed to:-Ensure Resident #53 and Resident #11's medical orders for scope of treatment (MOST) forms matched their physician's orders; and,-Ensure staff were able to locate the residents' MOST forms in order to follow the residents' choices for cardiopulmonary resuscitation (CPR).Findings include: I. Facility policy and procedure The Advance Directives and Advance Care Planning policy, reviewed [DATE], was received from the nursing home administrator (NHA) on [DATE] at 12:03 p.m. It read in pertinent part, Social services ensures that a copy of the advance directive is obtained for the resident's medical record and verifies that there is an appropriate physician's order in the resident's medical record as well. This review should focus on if the existing advance directives and advanced care planning match the current goals of care for the resident. The director of nursing (DON) or designee establishes a system to inform all direct care staff of the resident's DNR (do not resuscitate) status. II. Resident #53 A. Resident status Resident #53, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included multiple sclerosis (autoimmune disease of the central nervous system), dementia (disease that affects the brain), and lumbago with sciatica (chronic lower back pain involving the sciatic nerve). According to the [DATE] minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. B. Record review Review of Resident #53's February 2026 CPO identified the resident's COR status (cardiac or respiratory - whether or not the resident wants resuscitation in the event their heart/breathing stops) was DNR (do not resuscitate), ordered on [DATE]. Review of Resident #53's MOST form (a form sent with the resident upon transfer or discharge to communicate advance directives/resident wishes), dated [DATE], documented the resident wished to receive cardiopulmonary resuscitation (CPR), full medical treatment and intervention and artificial nutrition. -However, the information documented on the form was last reviewed with the resident in [DATE] and did not match the [DATE] physician's order for DNR status (see physician's order above). (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's COR status care plan, dated [DATE], documented the resident's COR status was addressed during the meeting and noted the resident remained a full COR status. -However, the care plan was not updated to reflect the [DATE] physician's order which identified the resident's status changed to DNR. C. Staff interviews Certified nurse aide (CNA) #1 was interviewed on [DATE] at 2:26 p.m. CNA #1 said was not sure where the MOST forms were located for the residents on the second floor. She said she was not sure how she would respond to someone if they asked what a residents' COR status was. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 2:40 p.m. LPN #1 said the code status of a resident could be found in one of two ways; either in the residents' electronic medical records (EMR), or in the green binder located at the nurses' station that housed the MOST forms. LPN #1 said it was important to ensure that both methods, the EMR and the MOST paper form, of indication were matching. LPN #1 looked at Resident #53's MOST form and the physician's order and said they did not match. LPN #1 said the nurses had the responsibility of ensuring a resident's MOST form was completed in case anything were to happen to the resident. LPN #1 said she was not sure how often the facility performed an audit to ensure the residents' MOST forms matched the physician's orders for resident's COR statuses. LPN #1 said she was fairly new to the facility and was still learning her role. She said she would ask her manager about the process and see to it that Resident #53's MOST form was revised to reflect the current physician's order for the resident's COR status. The DON and the regional clinical resource were interviewed together on [DATE] at 5:30 p.m. The DON said the nurses worked together, along with social services, to ensure the residents' MOST forms were completed upon admission to the facility. The DON said it was important to ensure physician's orders for residents' COR statuses matched the MOST forms so the residents' final choices for resuscitation were honored. The regional clinical resource said she did not know why Resident #53's MOST form did not match his physician's order for COR status. She said she would perform an immediate audit to ensure all residents' MOST forms and physician's orders had accurate and matching information for COR status. III. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included parkinsonism (a neurological disorder causing movement issues), type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and contractures (the permanent, abnormal tightening of skin, muscles, tendons, or ligaments, causing joint rigidity, pain, and severely reduced movement). The [DATE] MDS assessment revealed the resident was unable to complete the BIMS assessment. According to the staff assessment for mental status, the resident's cognitive skills for daily decision (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	making were severely impaired. The resident was dependent upon staff for personal hygiene, dressing, and assisting with eating. B. Record review Review of the facility's MOST form binder identified Resident #11 was a DNR status. Review of the electronic charting system identified Resident #11 as a full code. Review of the medication administration record (MAR) revealed Resident #11's code status was changed from full code (resident wanted all available life saving measures used to revive them if their breathing or heart stopped) to a DNR on [DATE] at 2:37 p.m., during the survey. C. Staff interviews CNA #4 was interviewed on [DATE] at 2:18 p.m. CNA #4 said in the case of an emergency, if a nurse had directed him to find the code status of a resident, he would check the online charting system on the wall. CNA #4 checked the charting system on the wall but said he could not find the code status there. CNA #4 said he would go to the computer charting system and check for the resident's code status there. CNA #4 checked the computer but could not find the code status of residents. CNA #4 then said he would instead ask another nurse for help and find out the code status for residents that way. LPN #3 was interviewed on [DATE] at 2:25 p.m. LPN #3 said nurses filled out the MOST forms with the residents and their families if needed. She said they completed MOST forms when residents were admitted to the facility or if the resident had a change of condition and wanted to change or update their MOST forms. LPN #3 said in the case of an emergency, staff should look in the MOST form binder for resident statuses. LPN #3 found Resident #11's code status in the MOST form binder where Resident #11's code status was a DNR. LPN #3 next looked in Resident #11's electronic charting system for her code status where the online code status documented the resident as a full code. LPN #3 said the electronic charting system was telling her Resident #11 was a full code and that was incorrect, because staff should always go off of the signed MOST form document in the binder. LPN #3 said the binder and the electronic charting system should show matching code statuses because staff would not want to make any mistakes with CPR. LPN #3 said medical records staff were responsible for ensuring code statuses matched in the binder and in the electronic charting system. LPN #3 said nursing staff were also responsible for ensuring the binder and electronic charting system code statuses matched because nurses helped residents fill out the code status and updated the MOST forms in the binder. She said after the MOST form was updated in the binder, that same nurse should then make sure the code status was correct in the electronic charting system as well. LPN #3 said social services, nurses and medical records staff worked together as a team to ensure everything was corrected.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to communicate effectively with the dialysis centers for two (#61 and #4) of two residents reviewed for dialysis out of 41 sample residents.Specifically, the facility failed to ensure dialysis communication forms between the facility and the dialysis center were thoroughly completed consistently for Resident #61 and Resident #4.Findings include: I. Facility policy and procedure The Hemodialysis Offsite policy and procedure, revised on 9/16/25, was provided by the nursing home administrator (NHA) on 2/27/2 at 3:54 p.m. It revealed in pertinent part, The facility assures that each resident receives care and services for the provision of offsite hemodialysis consistent with professional standards of practice, which includes: arrangements for safe transportation to and from the dialysis facility; ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments at a certified dialysis facility; and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility should provide immediate monitoring and documentation of the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications such as redness or edema. The care of the resident receiving dialysis services must reflect ongoing communication, coordination, and collaboration between the facility and the dialysis staff. The facility may wish to designate an associate to coordinate activities and communications with each dialysis facility with which they have arrangements to provide dialysis services. II. Resident #61 A. Resident status Resident #61, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included end stage renal disease (the irreversible loss of 85 to 90% of kidney function, where the kidneys can no longer support life), type 2 diabetes mellitus, blindness in one eye, and prior subdural hemorrhage (trauma-induced, accumulation of blood between the brain's outer covering and its surface). The 1/5/26 MDS assessment revealed the resident was unable to complete the BIMS assessment. According to the staff assessment for mental status, the resident's cognitive skills for daily decision making were severely impaired. Resident #61 required moderate assistance for dressing, bathing and personal hygiene. B. Record review Review of Resident #61's dialysis communications forms from 10/31/25 to 1/21/26. The forms consisted of a pre-dialysis assessment section, a section which gives information and assessment results during the dialysis treatment and a post-dialysis treatment assessment section. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pre-dialysis section was to be filled out by facility nursing staff and contained information about vital signs, lung sounds, assessment of the access site (the surgically created point on the body where blood was removed and returned during hemodialysis), whether or not the resident was on an antibiotic, whether or not a bruit (low pitched whooshing sound heard with a stethoscope over a fistula or graft indicating healthy blood flow through the vascular access site) or thrill (physical vibration or buzzing sensation felt with the fingertips over a vascular access site such as an arteriovenous fistula or graft) was present, and any medications or meals sent with the resident to the dialysis center. The dialysis center section of the communication form was to be filled out by dialysis staff. The section consisted of the dialysis center name, nephrologist (specialized physician who diagnoses and treats kidney diseases), vital signs taken, condition of the access site, whether or not a bruit and trill were present, type of vascular access site, and notes about amount of food consumed during the dialysis procedure. The post-dialysis center section was to be filled out by facility nursing staff and contained information about vital signs, lung sounds, assessment of the access site, whether or not the resident was on an antibiotic, whether or not a bruit and thrill were present, and whether or not there was a change of access site. Review of Resident #61's dialysis communication forms revealed the following: -The pre-dialysis center information was not filled out in its entirety on 12/5/25, 12/8/25, 1/5/26 and 1/19/26. The dialysis center information section was not filled out and was blank or nearly blank on 11/5/25, 11/21/25, 12/8/25 and 1/15/26. The post-dialysis section of the form was not filled out and was blank on 11/3/25, 12/1/25, 12/8/25 and 12/25/25. Review of Resident #61's progress notes, from 10/4/25 to 2/22/26, revealed no communication or documentation of phone calls from nursing staff to the dialysis center which indicated nursing staff contacted the dialysis center to retrieve the missing information from the dialysis appointments. C. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 2/26/26 at 12:13 p.m. LPN #4 said nurses filled out the top section of the dialysis communication forms before the resident went to dialysis. LPN #4 said the pre-dialysis section consisted of what the facility sent with the resident, the site assessment and the resident's vital signs. She said it was important to document whether or not there was a bruit or thrill before the resident left in order to make sure that the dialysis access site would work when the resident arrived at dialysis. LPN #4 said the dialysis center would fill out the middle section of the form and then facility nursing staff filled out the post-dialysis section of the communication form when the resident returned from dialysis. LPN #4 said the post-dialysis section consisted of the site assessment and other boxes nurses were supposed to fill out accordingly. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #4 said it was important to fill out the communication forms so that the facility and the dialysis center could properly communicate and to understand what changes were occurring with the resident. LPN #4 said if the dialysis center did not fill out their section of the form, the nurses had to call the dialysis center and get the information filled out. LPN #4 said if nurses had to call the dialysis center to fill out information on the form, it would be documented in the progress notes in the resident's electronic medical record (EMR). LPN #4 said the medical records department scanned the physical papers from the dialysis binders into the residents' EMRs under the document tab. LPN #4 said it was important for the dialysis center to fill out the post-dialysis weight value so that facility nursing staff could identify whether or not a resident would be at higher risk for falls upon return. She said that the more fluid dialysis pulled off of the resident, the more likely it was for the resident to be weaker. The medical records director was interviewed on 2/26/26 at 8:58 p.m. The medical records director said he scanned the dialysis communication forms from the dialysis binders into the residents' EMRs monthly. He said he began scanning them in October 2025 to the current day. The medical records director said he personally did not check the forms for completeness. He said nurses and the registered dietician looked at the documents for completion. III. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE] and re-admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, hypertensive chronic kidney disease, end stage renal disease (renal failure), dependence on renal dialysis, hemiplegia (paralysis) following cerebral infarction affecting left non-dominant side, amputation of left lower extremity and depression. The 12/4/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She used a wheelchair for mobility and required assistance from one staff member for toileting, personal hygiene, and transfers. The MDS assessment indicated the resident received hemodialysis (treatment to filter wastes and water from blood using an artificial membrane). B. Record review Review of Resident #4's February 2026 CPO revealed a physician's order for dialysis every Tuesday, Thursday, and Saturday, ordered on 6/1/24. Review of review of Resident #4's hemodialysis care plan, initiated 9/1/23, revealed the resident received hemodialysis. Interventions included encouraging the resident to go to scheduled dialysis appointments, observing and reporting signs and symptoms of renal insufficiency, including changes in level of consciousness, changes in skin turgor and changes in heart and lung sounds as needed (revised 12/1/25), observing and reporting bleeding, hemorrhage, signs and symptoms of infection or septic shock or peripheral edema as needed (revised 10/20/25) and assessing the resident's shunt (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	site (abnormal direct connection between an artery and a vein) for bruit (swishing sound) and thrill (buzzing vibration) in the upper leg (revised 9/8/23). Review of Resident #4's dialysis communication forms revealed the following: -The dialysis center's section of the form was not completed on 1/13/26, 2/7/26, 2/17/26 and 2/26/26. -The post-dialysis section of the form, to be completed by the facility, was not completed on 2/12/16, 2/24/26 and 2/26/26. Review of Resident #4's progress notes did not include communication notes with the dialysis center. C. Staff interviews Registered nurse (RN) #1 was interviewed on 2/26/26 at 12:30 p.m. RN #1 said all the nurses were responsible for documenting on the dialysis communication forms RN #1 said the nurse on duty was responsible for documenting the pre-dialysis and post-dialysis sections of the forms. RN #1 said every time the dialysis center staff did not document the dialysis section, the facility nurses should call the dialysis center, ask for the information and update the dialysis communication form. RN #1 said it was important to keep the dialysis communication form updated so the next nurse could have an idea about the resident's condition after dialysis. RN #1 said the dialysis communication forms were not uploaded to the resident's electronic medical record (EMR), but were kept in a dialysis binder. The director of nursing (DON) was interviewed on 2/26/26 at 7:25 p.m. The DON said the nurses were responsible for calling the dialysis center if the dialysis center did not complete the dialysis section of the document. The DON said the pre-dialysis section of the form needed to be completed to determine the resident's status before the resident went to dialysis, including the resident's pre-dialysis weight and vital signs. The DON said the post-dialysis section of the form was equally as important for the nurses to document. The regional clinical resource was interviewed on 2/26/26 at 7:25 p.m. The regional clinical resource said she was not sure whether the nurses were documenting the dialysis communication forms and calling the dialysis centers each time the dialysis center staff failed to document in the dialysis section.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who were trauma survivors, received culturally competent, trauma-informed care in accordance with professional standards or practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (#40) of two residents reviewed for trauma-informed care out of 41 sample residents. Specifically, the facility failed to ensure Resident #41 had a trauma-informed care plan which identified potential triggers that had the potential to re-traumatize the resident.Findings include:I. Facility policy and procedureThe Trauma-Informed Care policy and procedure, revised 1/6/26, was provided by the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, Based on the comprehensive assessment of a resident, this facility ensures that residents who are diagnosed with mental disorder and psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder, receive treatment and services in accordance with professional standards of practice, and has a comprehensive person-centered care plan that reflects the resident's goals to eliminate or mitigate triggers that may cause re-traumatization of the resident. II. Resident #41A. Resident statusResident #41, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included acute on chronic diastolic congestive heart failure, major depressive disorder and post-traumatic stress disorder (PTSD). The 12/3/25 minimum data set (MDS) assessment revealed Resident #41 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #41 had no documented behaviors. The MDS assessment identified Resident #41 had a diagnosis of PTSD. B. Resident interviewResident #41 was interviewed on 2/23/26 at 10:59 a.m. Resident #41 said she had trauma from when her husband completed suicide in front of her. She said he had shot himself. She said gunfire sounds were a trigger for her. C. Record review-Review of Resident #41's comprehensive care plan revealed there was not a trauma-informed care plan focus for the resident. Review of Resident #41's electronic medical record (EMR) revealed her most recent trauma-informed care assessment was dated 10/21/25. The assessment revealed the resident experienced trauma when her husband shot himself in front of her and her daughter. -However, the assessment did not document any triggers for the resident that could lead to re-traumatization of the resident. III. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 2/26/26 at 1:40 p.m. CNA #3 said Resident #41 did not have any trauma or PTSD. She said the only time that she had seen Resident #41 cry or have any other emotions other than being happy or mad, was when one of her close friends had passed away. The social services director (SSD) was interviewed on 2/26/26 at 6:14 p.m. The SSD said she was the person who created the residents' care plans for trauma and PTSD. She said the care plans for trauma and PTSD should be created when she completed the trauma-informed assessment when the residents first admitted to the facility or if something was brought up to her after admission. The SSD said the trauma-informed care plans should consist of specific triggers and interventions for mitigating the triggers that could re-traumatize a resident. She said it was important for floor staff to know when a resident had a history of trauma or PTSD so that the staff could help prevent any triggers or re-traumatization. She said Resident #41 did not have her PTSD care planned because she said she did not have any triggers. She said if she had mentioned any triggers she would have care planned it immediately. -However, during an interview on 2/23/26, Resident #41 indicated gunfire was a trigger for her (see resident interview above).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#17) of one resident out of 41 sample residents received dental services timely. Specifically, the facility failed to assist Resident #17 with finding another dental service that accepted his dental insurance.Findings include:I. Facility policy and procedureThe Dental Services policy and procedure, reviewed 9/3/25, was provided by the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, The facility is responsible for assisting the resident in obtaining needed dental services, including routine dental services. The facility will provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident. Residents will be assisted with making appointments and arranging transportation to and from the dentist's office if necessary.II. Resident #17 A. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic diastolic congestive heart failure, chronic kidney disease and atherosclerotic heart disease. The 12/4/25 minimum data set (MDS) assessment revealed Resident #17 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment revealed that Resident #17 was independent with most of his activities of daily living (ADL), including oral hygiene. He needed assistance with showering and footwear. B. Resident interviewResident #17 was interviewed on 2/23/26 at 5:30 p.m. Resident #17 said he saw the dentist when they came to the facility and the dentist had recommended that he have a procedure done. He said the dentist came back and took some Xrays for the procedure. He said when he went to the appointment to have the procedure done, he sat in the waiting room for more than an hour and then he said he was told that the dental office did not accept his insurance. He said he had not heard anything about trying to go to a different dental office to have the procedure done. dent #17 was interviewed a second time on 2/24/26 at 10:30 a.m. Resident #17 said had pain on the lower left side of his mouth and said it felt like cavity pain. He said he remembered someone saying something about his wisdom teeth but he could not remember what they had said. C. Record reviewResident #17's ADL care plan, initiated 9/10/24 and revised 9/10/24, documented Resident #17 had a self-care performance deficit related to pain, decreased mobility, incontinence, medications, diuretics and decreased ADL functions. Interventions related to oral care revealed Resident #17 required assistance of one staff member with oral care. Resident #17's Kardex (staff directive tool) revealed he needed the assistance of one staff member for oral hygiene and to use a soft-bristle toothbrush. Review of Resident #17's electronic medical record (EMR) revealed a dental service note, dated 6/24/25. The note documented Resident #17 was seen for a consultation for a planned extraction of two teeth. The note documented the necessity of an external dental specialist for the procedure and Resident #17 would have to coordinate with the referred specialist to schedule the extraction. A health status note, dated 8/14/25 at 10:45 a.m., documented the dental office where Resident #17's oral surgery was scheduled to take place on 8/20/25 had called to let the facility know that they did not take Resident #17's dental insurance and Resident #17 would have to pay out of pocket. The note documented Resident #17 said to cancel the appointment and that he was not having tooth pain. A second dental service note, dated 9/5/25, revealed the dental provider discussed the need for Resident #17 to have his teeth extracted. The note documented that there was a scheduling issue when he was supposed to go in August 2025. The note documented that Resident #17 lost a broken tooth while brushing his teeth. The note documented the dental service would attempt to get a new referral as soon as possible. -However, there was no additional documentation to indicate the facility made further attempts to get a new appointment scheduled for Resident #17 for his oral surgery. III. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 2/26/26 at 8:43 a.m. CNA #3 said Resident #17 had never mentioned mouth or tooth pain to her. The social services director (SSD) was interviewed on 2/26/26 at 6:14 p.m. The SSD said she was the person who (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled and coordinated ancillary services, including dental services. She said she was responsible for helping with coordinating any follow-up dental appointments. She said she was not aware that Resident #17's insurance was not accepted at his dental appointment for the oral surgery. She said she asked him how his appointment went and he had told her that he did not get anything done. She said she did not follow up with him any further. She said that in September 2025, the dental service company was going to refer Resident #17 for another dental appointment. She said she was unsure of why Resident #17 had not been seen or referred to another appointment.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement policies and procedures related to pneumococcal immunizations for one (#36) of five residents reviewed for immunizations out of 41 sample residents. Specifically, the facility failed to ensure Resident #36 received pneumococcal immunization when consent was given.Findings include:I. Professional Reference According to the Centers for Disease Control and Prevention's (CDC) Pneumococcal Vaccination, revised 2/25/26, retrieved on 3/2/26 from https://www.cdc.gov/pneumococcal/vaccines/index.html, CDC recommends pneumococcal vaccination for all adults 50 years or older.II. Facility policy and procedureThe Vaccination of Older Adults policy, revised 1/28/25, was received from the nursing home administrator (NHA) on 2/27/26 at 3:54 p.m. It read in pertinent part, Consents and declinations should be captured using an informed consent form for the vaccine.Education, assessment findings, administration, refusal or did not receive due to medical contraindications, and monitoring are documented in the resident's medical record. Update immunization record in the electronic health record. III. Resident #36 A. Resident statusResident #36, age greater than 65, was admitted to the facility on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses including acute kidney failure (sudden loss of kidney function), unspecified atrial fibrillation (rapid and quivering heartbeat) and chronic venous hypertension (elevated blood pressure in the leg veins).The 2/5/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMs) score of 14 out of 15. The MDS assessment indicated the resident was not up-to-date with pneumococcal vaccination due to the vaccine not being offered by the facility.B. Record reviewReview of Resident #36's electronic medical record (EMR) revealed Resident #36 consented to receive the pneumococcal vaccine on 9/9/25, during her admission to the facility.-However, there was no documentation in the resident's EMR to indicate the pneumococcal vaccine had been administered to the resident.The facility obtained a second consent for the pneumococcal vaccine from Resident #36 on 12/28/25, however, the resident declined the pneumococcal vaccine at that time. IV. Staff interviewThe infection preventionalist (IP) was interviewed on 2/26/26 at 5:45 p.m. The IP said Resident #36 had consented to receive the pneumococcal vaccination on 9/9/25. The IP did not know why Resident #36 did not receive her pneumococcal vaccination from the date of initial consent 9/9/25 upon her admission to the facility.The IP said a second consent for the pneumococcal vaccine was obtained from the resident on 12/28/25, however, she said the resident declined at that time and she did not know why the resident declined the vaccination on 12/28/25. The IP confirmed Resident #36's EMR failed to provide documentation of attempts to administer the pneumococcal vaccination to the resident, education provided to the resident at time of the attempts and/or a reason why the resident chose to decline consent for the vaccination in December 2025.