STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065237	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Care Center	1200 Village Rd Carbondale, CO 81623

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51163 Based on observations, record review and interviews, the facility failed to ensure residents had the right to a dignified existence for three (#6, #27 and #4) of three residents out of 28 sample residents reviewed. Specifically, the facility failed to: -Provide Resident #6 and Resident #27 with a dignified dining experience; -Provide Resident #4 with privacy and dignity while he used his urinal in his room; and, -Ensure residents were not discussed by staff in areas where the conversations could be overheard by others. Findings include: I. Facility policy and procedure The Dignity policy and procedure, dated 5/16/19, was provided by regional director of clinical services (RDCS) #2 on 8/29/24 at 2:10 pm. It revealed in pertinent part, Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as honor and value their input. Promote resident independence and dignity while dining, such as avoiding: -Staff standing over residents while assisting them to eat; and, -Staff interacting /conversing only with each other rather than with residents while assisting with meals. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff should not discuss residents in settings where others can overhear private or protected information or document in charts/electronic health records where others can see a resident's information. II. Resident #6 A. Resident status Resident #6, age 89, was admitted on [DATE]. According to the August 2024 computerized physician order (CPO), diagnoses included major depressive disorder, other Alzheimer's disease, restlessness and agitation. The 6/5/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments and was unable to complete the brief interview for mental status (BIMS). Resident #6 required set up and clean up assistance with meals and was dependent on staff for the rest of her activities of daily living (ADL). B. Observations On 8/26/24 at approximately 12:15 p.m. Resident #6 was sitting at a dining room table awaiting her meal. The resident was served her meal in four individual bowls and a small dessert bowl. The registered dietitian (RD) walked up to Resident #6's table and pushed all but one of the bowls to the top of the table, out of reach of the resident. The RD did not explain what she was doing or speak to Resident #6 prior to moving the bowls. Resident #6 was left with one bowl but did not get the choice of which food items she wished to eat. On 8/28/24 during a continuous observation of the breakfast meal, beginning at 8:28 a.m. and ending at 8:41 a.m., the following was observed: At 8:28 a.m. Resident #6 had four individual bowls of food in front of her. She was eating from two of the bowls. At 8:41 a.m. the RD walked up to the resident and removed all but one of the bowls. The other bowls were put out of reach for the resident. The RD did not speak to the resident as she moved the bowls. Resident #6 was not provided a choice of which food items she wanted to eat. C. Record review Resident #6's dietary care plan, revised on 3/12/24, revealed Resident #6 could dine independently if needed due to agitation and, at times, disruptive behavior. Resident #6 needed supervision, some assistance and encouragement at times and adequate time to eat. -The care plan failed to indicate Resident #6 needed to have her meal served in individual bowls and only be given one bowl at a time. D. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RD was interviewed on 8/29/24 at approximately 10:00 a.m. The RD said Resident #6 did better eating her meal when all of the bowls were not directly in front of her. She said having all of the bowls at once made the resident more agitated. The RD said she would work on ensuring that she spoke to the resident prior to moving the bowls. -However, observations of Resident #6 did not reveal that the resident was agitated while eating her meal with all of the bowls sitting directly in front of her (see observations above). The director of nursing (DON) was interviewed on 8/29/24 at approximately 4:00 p.m. The DON said Resident #6 was cognitively impaired. She said providing only one bowl at a time for the resident was better for the resident. The DON said the RD moving the bowls so Resident #6 only had one bowl at a time was not disrespectful or discourteous to the resident. 48412 III. Resident #27 A. Resident status Resident #27, age less than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included Down's syndrome, unspecified convulsions, Parkinson's disease with dyskinesia (involuntary movements of the body), dysphagia of oral phase (difficulty swallowing), generalized anxiety disorder, panic disorder, dementia with anxiety and mood disturbances and visual hallucinations. The 6/28/24 MDS assessment revealed Resident #27 had a severe cognitive impairment with a BIMS score of four out of 15. B. Resident representative interview Resident #27's representative was interviewed on 8/27/24 at 7:33 p.m. The resident's representative said Resident #27 would benefit from one-on-one activities and conversations with staff because he had a hard time socializing after his Parkinson's disease progressed. She said the resident needed someone to spend time with him throughout the day when the family was unable to visit. The resident's representative said Resident #27 told her, on 8/25/24, that he wanted the staff to sit in his room with him. The resident's representative said the resident had told her that the staff did not need to talk to him, he just wanted someone's companionship. The resident's representative said Resident #27 ate well during meals when the person assisting him socialized with him. She said she observed some meals and the CNAs assisted two residents at a time. She said the CNAs did not interact with the residents. She said the nurses communicated with Resident #27 when assisting him at meals. The resident's representative said Resident #27 was a very social person but his medical issues affected how he communicated and he was lonely because the CNAs failed to socialize with him throughout the day and at meals. C. Observations (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 8/28/24, beginning at 11:40 a.m. and ending at 12:24 p.m., the following was observed: At 11:40 a.m. Resident #27 was in his wheelchair in the middle of the dining room. At 11:43 a.m. an unidentified certified nurse aide (CNA) assisted Resident #27 to his seat at the resident assistance table in the dining room. At 11:48 a.m. Resident #27 was sitting by himself and the staff were interacting with all of the residents at the table except for Resident #27. At 11:56 a.m. CNA #1 put a clothing protector on Resident #27 and sat next to him. CNA #1 did not socialize with Resident #27. CNA #1 was interacting with a female resident at the table. At 11:57 a.m. Resident #27 tried talking to CNA #1. CNA #1 listened to the resident for 10 seconds and looked around the room which ended the conversation. At 11:58 a.m. an unidentified dietary aide (DA) served drinks to the residents at the resident assistance table. The DA provided Resident #27 milk and gatorade but did not ask the resident what he wanted to drink. The DA did not interact with the resident but spoke to CNA #1 in Spanish. At 12:00 p.m. CNA #1 was not socializing or offering drinks to Resident #27. At 12:02 p.m. CNA #1 moved Resident #27's legs in his wheelchair without asking if he wanted to move or notifying the resident. CNA #1 put the cup's spout to Resident #27's lips without asking if he wanted a drink and did not interact with the resident. At 12:03 p.m. CNA #1 gave Resident #27 a drink while she talked to another resident at the resident assistance table and did not interact with Resident #27. At 12:10 p.m. Resident #27 told CNA #1 something and motioned to his left hand. CNA #1 held his hand and massaged his palm as she interacted with other staff in the dining room. At 12:12 p.m. CNA #1 assisted Resident #27 with eating and rubbed her left hand along his back but she did not talk to the resident. At 12:19 p.m. CNA #1 was assisting Resident #27 with his meal and closing her eyes for a few seconds. She repeatedly blinked her eyes to wake herself up. At 12:20 p.m. CNA #1 closed her eyes for a few seconds while she had the spoon up to Resident #27's mouth. At 12:21 p.m. CNA #1 again closed her eyes for a few seconds. She opened her eyes and rubbed her face before feeding Resident #27 another bite of his lunch. At 12:22 p.m. CNA #1 had her head on her hand while she provided Resident #27 another bite of food and she closed her eyes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:24 p.m., the DON asked CNA #1 to complete a different task outside of the dining room. The DON took over assisting Resident #27. D. Record review Resident #27's activity care plan, revised on 7/26/24, revealed, due to his physical limitations, he was dependent on staff to meet his emotional, intellectual, physical and social needs. The intervention was providing the resident with one-on-one activities because he liked to converse. Resident #27's activities of daily living (ADL) care plan, revised on 9/11/21, revealed Resident #27 required extensive assistance from one staff member while eating. Resident #27's communication care plan, revised on 2/26/24, revealed the resident had a communication problem which referred to his fear or shyness and Down's syndrome. Interventions included being conscious of Resident #27's position when in groups, activities and the dining room to promote proper communication with others, allowing the resident adequate time to respond, repeating as necessary, not rushing the resident, requesting clarification from the resident to ensure understanding, facing the resident when speaking and making eye contact, encouraging Resident #27 to continue stating his thoughts even if he was having difficulty, keeping communication with the resident focused on the resident and being conscientious of what was talked about within listening distance because Resident #27 has excellent hearing and internalized and was stressed by conversations overheard. A review of Resident #27's Kardex (a staff directive tool) revealed the resident needed extra time to respond to questions and instructions, the resident occasionally needed to be asked yes or no questions to determine his needs and Resident #27 needed to be offered gatorade and his favorite drink of choice during and in between meals to promote hydration. E. Staff interviews The nursing home administrator (NHA) was interviewed on 8/29/24 at 4:42 p.m. The NHA said the incident with CNA #1 falling asleep while she assisted him at lunch was going to be investigated. The NHA said she reminded all of the staff that if they felt tired while assisting a resident at a meal to inform another staff member and switch duties. The NHA said it put the Resident #27 at a higher risk of choking when CNA #1 fell asleep while she assisted him. She said CNA #1 was not paying attention and the resident had a hard time communicating. She said the staff needed to communicate with all of the residents, but especially the residents that were being assisted at meals. Registered nurse (RN) #2 was interviewed on 8/29/24 at 12:25 p.m. RN #2 said when she assisted residents with meals she socialized with the residents. IV. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included bilateral conductive hearing loss, legal blindness, difficulty in walking and muscle weakness. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/19/24 MDS assessment revealed Resident #4 had moderate cognitive impairments with a BIMS score of 12 out of 15. B. Observations During a continuous observation on 8/28/24, beginning at10:30 a.m. and ending at 12:45 p.m., the following was observed: At 10:30 a.m. Resident #4 was lying on his bed with his window curtains and the bedroom door open. At 10:34 a.m. an unidentified CNA answered Resident #4's call light. The unidentified CNA provided the resident with his urinal and said You are welcome as she left the room. The unidentified CNA left his bedroom door and window curtains open. At 10:35 a.m. Resident #4 pulled down his pants and had the urinal in his left hand. Resident #4 used his right hand to expose his penis and put it inside the opening of the urinal. Resident #4 used the urinal while he laid in his bed with his pants pulled down and his window curtain and door were left open. At 10:38 a.m. the same unidentified CNA walked by Resident #4's door and saw he was still using his urinal in his bed and walked by without closing his door. At 10:41 a.m. the same unidentified CNA walked by Resident #4's door and kept walking down the hallway. Staff were observed in the living room of the dementia unit across the courtyard through Resident #4's window. At 10:42 a.m. the physical therapy assistant (PTA) walked by Resident #4's room. He told Resident #4 How about some privacy and closed the privacy curtain in the bedroom. The PTA left the room but left the resident's window curtains open. At 11:09 a.m. Resident #4 activated his call light. RN #3 answered his call light and brought the resident a glass of water. RN #3 left Resident #4's privacy curtain closed but left his window curtains open. At 11:25 a.m., Resident #4 was observed with his privacy curtain closed and his pants were pulled up while laying in bed. He was waiting to go to the dining room for lunch. C. Record review Resident #4's ADL care plan, revised on 3/12/24, revealed the resident had an ADL self-care deficit due to impaired balance, visual deficits, generalized weakness and a history of a rotator cuff tear. Resident #4 was able to self-propel independently using his wheelchair, he required limited assistance by one staff member to turn and reposition in bed, he required one person assistance with toileting and he was able to transfer with one person assistance. D. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The regional vice president (RVP) and the NHA were interviewed together on 8/28/24 at 1:55 p.m. The RVP said privacy needed to be provided to the residents anytime care was provided, which included when Resident #4 used a urinal in bed. The NHA said privacy was important because Resident #4 did not need to be exposed to other residents and other residents did not need to be exposed to Resident #4 while he was using the urinal. The NHA was interviewed again on 8/29/24 at 4:42 p.m. The NHA said when a resident used the restroom, the door and the curtains needed to be closed to provide the resident with privacy and dignity. RN #2 was interviewed on 8/29/24 at 12:25 p.m. RN #2 said when a resident used the urinal, the privacy curtain or the bedroom door needed to be closed. She said she never thought about closing the window curtains but she said the curtains probably needed to be closed as well. The RVP and the NHA were interviewed together again on 8/29/24 at 7:55 p.m. The NHA said the leadership team met once a month to discuss areas of improvement within the facility to better serve the residents. The NHA said the facility had not identified privacy or dignity as an area for improvement. V. Failure to ensure residents were not discussed by staff in areas where the conversations could be overheard by others A. Observations On 8/26/24 during a continuous observations of the dining room, beginning at 12:00 p.m. and ending at 12:30 p.m., the following was observed: The main dining room had approximately ten tables. During the meal service, approximately 18 residents were in the dining room. At approximately 12:00 p.m. an unidentified resident asked for creamer. for their coffee. The RD was heard telling the resident You don' t like creamer, you like your coffee black. -The RD did not provide the resident with creamer as requested. At 12:15 p.m. an unidentified certified nurse aide (CNA) was observed standing while assisting Resident #24 with eating their meal. At approximately 12:30 p.m. the RD was heard talking loudly about other residents ' decline and needing to change their diet orders. The RD was heard asking multiple residents about their dentures and why they did not want to wear them. The RD was heard talking about different resident's preferences to other residents' family members. The RD could be overheard throughout the dining room. -Throughout the continuous observation, the RD was walking from resident to resident and assisting them with their meals while standing up. The RD conversed with other employees instead of the residents while she was assisting them to eat their meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interviews The RD was interviewed on 8/29/24 at approximately 10:00 a.m. The RD said she knew her voice was loud. She said she had been told she was loud before. She said when she was in the kitchen she had to speak loudly because of the overhead fans. She said she viewed the facility as a family and she wanted to help everyone and that was why she would talk to all of the residents. The social services director (SSD) was interviewed on 8/29/24 at 3:51 p.m. The SSD said the facility had provided staff with education on dignity and respect. She said staff received the education when new employees were hired and then annually thereafter. She said all residents were to be treated with respect and dignity. The SSD said she would review the resident rights with all staff.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to conduct a preadmission screening resident review (PASRR) for two (#20 and #10) of two residents reviewed for PASRR out of 28 sample residents. Specifically, the facility failed to submit a new PASRR Level I after Resident #20 and Resident #10 were admitted to the facility with a provisional PASRR and remained in the facility for more than 30 days. Findings include: I. Facility policy and procedure The Pre-Admission Screening and Resident Review (PASRR) policy, revised [DATE], was provided by the regional director of clinical services (RDCS) #1 on [DATE] at 2:10 p.m. It read in pertinent part, Ensure the Level I PASRR screening has been completed on potential admissions prior to admission. A negative Level I screen permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later. A record of the pre-screening should be retained in the resident's medical record. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASRR Level II, which must be conducted prior to admission to a nursing facility. When a Level II PASRR screening is warranted it must be obtained as well as a determination letter prior to admission. The Level II PASRR cannot be conducted by the nursing facility. The Level II PASRR determination and the evaluation report specify services to be provided by the facility or specialized services defined by the state; and, Recommendations from PASRR Level II determination and PASRR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care. II. Resident #20 A. Resident status Resident #20, age over 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included generalized anxiety disorder, depression, bipolar disorder, cognitive-communication deficit, other symptoms and signs involving cognitive functions and awareness and adjustment disorder with depressed mood. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] minimum data set (MDS) assessment revealed Resident #20 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #20 was documented as not having any behavioral symptoms. B. Record review Resident #20's care plan, revised [DATE], documented she received Sertraline (antidepressant medication) for her depression and she received Abilify (antipsychotic medication) for behavior management with Resident #20's bipolar disorder. Resident #20's behavioral care plan, revised [DATE], documented the resident had chronic depression and generalized anxiety disorder. Interventions included administering medications as ordered, discussing the resident's fears or concerns as needed, encouraging Resident #20 to talk about her life, offering the resident music, offering one-on-one attention and monitoring for signs and symptoms of depression. A provisional (temporary) PASRR was uploaded into Resident #20's electronic medical record (EMR) on [DATE]. The provisional PASRR read in pertinent part, The review of the submitted PASRR Level I screen resulted in a finding of a known or suspected mental illness and there were indicators for a qualifying provisional admission. The facility is responsible for submitting a new Level I PASRR screen if the member (resident) is anticipated to reside in the facility beyond the approved provisional admission timeline as noted below. Exempted hospital discharge: The need for a nursing home regarding convalescent (recovery) care due to a discharge from an acute care hospital where the rehabilitation care relates to the reason for the hospitalization and has been certified by the attending physician to likely require fewer than 30 days of nursing services. -However, the facility failed to submit a new Level I PASRR screen when the resident remained in the facility longer than 30 days. A PASRR Level I screen was approved for Resident #20 on [DATE] (over six months after the provisional PASRR expired) and documented the resident needed a PASRR Level II due to evidence of a known or suspected PASRR condition which required further evaluation. A PASRR Level II was approved for Resident #20 on [DATE] (during the survey). It documented the following specialized services were required or recommended for Resident #20: Medication review, individual therapy and a further neurocognitive test to verify the diagnosis of a neurocognitive disorder and to establish a baseline. -However, the facility's delay in submitting a new Level I PASRR screen when the resident remained in the facility after 30 days, resulted in a nine-month delay of Resident #20 receiving the recommended individual therapy and neurocognitive testing. III. Resident #10 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #10, age over 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included generalized anxiety disorder, unspecified disorder of the brain, dementia with anxiety and unspecified symptoms and signs which involved cognitive functions and awareness. The [DATE] MDS assessment revealed Resident #10 had a severe cognitive impairment with a BIMS score of six out of 15. Resident #10 did not have documented behaviors. B. Record review Resident #10's activity care plan, revised on [DATE], documented the resident had little to no activity involvement due to her anxiety, depression and disinterest. Interventions included the resident preferred to watch television, listen to music, socialize with her hearing aids, family visits and stay up-to-date on current events. Resident #10's care plan, revised on [DATE], documented Resident #10 used Escitalopram (antidepressant medication) for her dementia with anxiety. Interventions included administering antidepressant medication as ordered and monitoring for side effects and effectiveness and educating the resident and family about the risks and benefits of the medication. A provisional PASRR was uploaded into Resident #10's EMR on [DATE]. The provisional PASRR read in pertinent part, The review of the submitted PASRR Level I screen resulted in a finding of a known or suspected mental illness and there were indicators for a qualifying provisional admission. The facility is responsible for submitting a new Level I PASRR screen if the member (resident) is anticipated to reside in the facility beyond the approved provisional admission timeline as noted below. Exempted hospital discharge: The need for a nursing home regarding convalescent (recovery) care due to a discharge from an acute care hospital where the rehabilitation care relates to the reason for the hospitalization and has been certified by the attending physician to likely require fewer than 30 days of nursing services. -The resident's EMR did not reveal that a new PASRR Level I had been submitted by the facility after Resident #10 remained in the facility longer than 30 days. A PASRR Level I screen was submitted for Resident #10 on [DATE] (during the survey). IV. Staff interview The social services director (SSD) was interviewed on [DATE] at 4:25 p.m. The SSD said when residents were admitted to the facility a Level I PASRR screen was completed by the hospital. She said recently the hospital was only completing provisional PASRR screens instead of a Level I PASRR. She said the admissions coordinator reviewed the PASRRs during the time of the resident's admission. The SSD said the provisional PASRR gave her 30 days to submit a new Level I PASRR screen if the resident was not going to be discharged by the end of the 30 days. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said Resident #20 was admitted in [DATE] and she did not have a social services assistant at the time to help her with PASRRs. The SSD said she missed submitting a new Level I PASRR for Resident #20 when the resident remained in the facility longer than 30 days. The SSD said Resident #10 was readmitted to the facility in [DATE]. The SSD said she missed submitting a new Level I PASRR for Resident #10 when the resident remained in the facility longer than 30 days. She said she submitted the new PASRR Level I screen earlier that day ([DATE]). The SSD said she completed an audit of the rest of the residents in the facility (during the survey) and did not find any other PASRRs that were not completed correctly. The SSD said she planned to complete weekly audits to ensure residents had the appropriate PASRRs submitted in a timely manner.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on record review and interviews, the facility failed to ensure four (#241, #242, #36, and #239) of five residents out of 28 sample residents had a completed baseline care plan within 48 hours of admission. Specifically, the facility failed to ensure that Resident #241, Resident #242, Resident #36 and Resident #239 had baseline care plans completed within 48 hours of admission and/or baseline care plans which addressed all of the minimum requirements, including initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, preadmission screening and resident review (PASARR) recommendation, if applicable. Findings include: I. Facility policy and procedure The Baseline Care Plan policy, revised 8/11/23, was provided by the regional director of clinical services (RDCS) #1 on 8/29/24 at approximatly 2:00 p.m. It revealed in pertinent part, A baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. The baseline care plan must include, but is not limited to: -Initial goals based on admission orders; -Physician orders; -Dietary orders; -Therapy services; -Social services; and, -PASARR recommendation, if applicable The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of admission and meets the requirements listed above. II. Resident #241 A. Resident status (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #241, age 79, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of left femur (break in the femur), unspecified dementia, severe, unspecified osteoarthritis (arthritis), unspecified urinary incontinence and history of falling. The 7/5/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The MDS assessment further revealed Resident #241 needed set up and clean up assistance for meals, partial assistance with bathing, toileting and upper body dressing and substantial assistance with lower body dressing. B. Record review -Review of Resident #241's electronic medical record (EMR) revealed the facility failed to complete a baseline care plan for the resident within 48 hours of the resident's admission. -Additionally, the facility failed to develop a comprehensive care plan in place of a baseline care plan within 48 hours of admission. -The care plan for antidepressant, antipsychotic and anti-anxiety medications was not initiated until 7/15/24 and the dietary care plan was not initiated until 7/23/24. III. Resident #242 A. Resident status Resident #242 age 80, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included displaced trimalleolar fracture of right lower leg (fracture of the ankle), unspecified fracture of the lower end of the right radius (fracture of the lower right arm), cervicalgia (neck pain), rotator cuff tear or rupture of left shoulder, rotator cuff tear or rupture of right shoulder, chronic kidney disease stage 3, fibromyalgia (widespread body pain and tiredness). The 8/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The MDS assessment further revealed Resident #242 needed set up and clean up assistance for meals, oral hygiene and partial assistance for bathing and upper body dressing and needed substantial assistance with toileting and lower body dressing. B. Record review -Review of Resident #242's EMR revealed a baseline care plan, dated 8/21/24, failed to include advance directives, COR status, dietary orders and therapy services, which were ordered. IV. Resident #36 A. Resident status (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36, age 71, was admitted on [DATE]. According to the August 2024CPO, diagnoses included muscle weakness, Raynaud's syndrome (parts of the body feel numb and cool due to small arteries constricting blood flow) without gangrene, dorsalgia unspecified (back pain), history of malignant neoplasm (cancer) of unspecified site of lip, oral cavity, and pharynx, facial weakness, cognitive communication deficit and pneumonitis (lung infection) due to inhalation of food and vomit. The 8/2/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. The MDS assessment further revealed that Resident #36 needed supervision or touching assistance with personal hygiene and upper body dressing and needed partial to moderate assistance with bathing/showering and lower body dressing. B. Record review -Review of Resident #36's EMR revealed that the baseline care plan, dated 7/31/24, failed to document advance directives, COR (resuscitation) status, dietary orders (the resident was to receive nothing by mouth and received nutrition and hydration through a tube feeding), or therapy services, which were ordered. -The dietary care plan was not initiated until 8/5/24. The baseline care plan failed to address the resident's activities of daily living self-care deficit until 8/12/24. V. Resident #239 A. Resident status Resident #239, age 80, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included pneumonia, sleep related hypoventilation, hypertension and hepatitis C. B. Record review -Review of Resident #239's EMR revealed that a baseline care plan was not completed for the resident. The comprehensive care plan, initiated on 8/7/24, initiated activities of daily living and discharge plan within 48 hours of the resident's admission to the facility. -However, a fall and history of falls care plan was not initiated until 8/12/24, a dietary care plan was not initiated until 8/20/24 and a therapy services care plan was not initiated VI. Staff interviews Registered nurse (RN) #2 was interviewed on 8/29/24 at 8:54 a.m. RN #2 said when a resident was admitted to the facility, the RN had to initiate the care plan and enter the pertinent information about continence care and other pertinent care plan areas. RN #2 said the MDS coordinator (MDSC) completed the rest of the care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDSC was interviewed on 8/29/24 at approximately 1:00 p.m. The MDSC said the baseline care plan needed to be completed within 48 hours. She reviewed the EMRs for Resident #241, #242, #36, and #239. She said the baseline care plans for each resident were incomplete or had not been completed at all. She said the care plans were not completed within 48 hours of the residents's admissions to the facility. The MDSC said she would begin an audit to ensure the baseline care plans for all residents were completed timely following admission to the facility.

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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** 51163 Based on observations, record review and interviews, the facility failed to ensure one (#24) of two residents reviewed for assistance with activities of daily living (ADL) out of 28 sample residents received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure Resident #24 was repositioned timely Findings include: I. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dysphagia (difficulty swallowing), prediabetes and chronic kidney disease stage 3. According to the 8/5/24 minimum data set (MDS)assessment the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. Resident #24 required substantial to maximum assistance with mobility and transfers. B. Observations During a continuous observation on 8/28/24, beginning at 8:47 a.m. and ending at 1:10 p.m. the following was observed: At 8:46 a.m. the resident was assisted away from the table. She was assisted to her room in her tilt back wheelchair. She was sitting in an upright position in her room. At 8:55 a.m. the resident continued to sit in her tilt back wheelchair. The wheelchair was in the upright position. At 9:23 a.m. the resident continued to sit in the same position. Certified nurse aide (CNA) #4 was talking with the resident. CNA #4 did not offer to reposition the resident. At 9:49 a.m. the resident remained in the same position and was sleeping in her chair. At 9:51 a.m. the resident continued to stay in her room in an upright position in her tilt back wheelchair. At 11:05 a.m. CNA #4 asked the resident if she wanted to go to trivia. -She did not offer to reposition Resident #24. The resident continued sitting in the wheelchair in the upright position. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:50 a.m. the resident was assisted to the dining room table. At 12:26 p.m. the resident was assisted back to her room. -The resident was not repositioned. At 12:29 p.m. the resident asked CNA #1 to help lay her down. CNA #1 said she would have to wait a bit as she needed to get some help. At 1:10 p.m. CNA #1 assisted the resident to the shower. -Resident #24 was not repositioned from 8:55 a.m. until 1:10 p.m. C. Resident's representative interview Resident #24's representative was interviewed on 8/29/24 at 11:30 a.m. The resident's representative said she had a special chair made which tilted back for Resident #24. She said it tilted back so that way her positioning was changed. D. Record review The skin care plan, revised on 8/18/24, revealed the resident was at risk for break in skin integrity including pressure related injury related to impaired mobility and function, weakness, incontinence, cognitive deficits and risk for malnutrition. Pertinent interventions included assisting Resident #24 with repositioning every two hours and as needed. The Kardex (staff directive for person centered care), dated 8/29/24, documented the resident required extensive assistance of one to two staff members for transfers with the mechanical hoyer lift. E. Staff interviews Registered nurse (RN) #1 was interviewed on 8/28/24 at 12:30 p.m. RN #1 said Resident #24 was unable to move on her own. He said she required assistance from two staff members to transfer and reposition. He said the resident was at risk for skin breakdown because she had lack of mobility and was also incontinent of urine. RN #1 said Resident #24 needed to be repositioned every two hours. The director of rehabilitation (DOR) was interviewed on 8/29/24 at approximately 1:00 p.m. The DOR said Resident #24 had a tilt back wheelchair which was specially ordered. The DOR said titting the wheelchair back helped with the repositioning of the resident and relieved pressure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure two (#37 and #1) of two residents out of 28 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to ensure Resident #37 and Resident #1 received quality care when the residents' physicians did not respond timely after both residents experienced a change of condition. Findings include: I. Professional reference [NAME], P.A., [NAME], A.G., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 1115, read in pertinent part: Effective communication and teamwork are essential for the delivery of high-quality, safe patient care. To avoid communication failures that can lead to unanticipated adverse events in patients, nurses must speak up when they have concerns and take the necessary steps to communicate assertively and collaboratively with the healthcare team. II. Facility policy and procedure The Changes in Resident's Condition or Status policy, revised 8/9/23, was provided by regional director of clinical services (RDCS) #1 on 8/29/24 at 2:10 p.m. It read in pertinent part, This facility will notify the resident, his or her primary care provider and resident representative of changes in the resident's condition or status. III. Resident #37 A. Resident status Resident #37, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included dementia, chronic obstructive pulmonary disease (COPD), occlusion and stenosis of the right carotid artery, cognitive-communication deficit, dysphagia and heart failure. The 5/16/24 minimum data set (MDS) assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. Resident #37 had an impairment to both arms and both legs. B. Record review Resident #37's Medical Orders for Scope of Treatment (MOST) form revealed the resident had a do not resuscitate status, however, the resident was okay with medical treatment at the hospital except for a breathing machine or being admitted into the intensive care unit (ICU). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note dated 7/3/24 documented a message was left with the resident's representative and physician because the resident tested positive for COVID-19 and isolation precautions were started. The physician ordered Paxlovid (medication used to treat COVID-19) 150 milligrams (mg). A communication with physician note dated 7/3/24 at 2:43 p.m. documented the nurse left a message for the physician because Resident #37 was unable to take Paxlovid because the resident required her medications to be crushed. According to the facility's pharmacist, Paxlovid could not be crushed. The nurse requested the physician to advise the nurse what the next step was. An infection note dated 7/4/24 documented the resident was on isolation precautions due to being positive for COVID-19. The resident denied pain at the time of the assessment and her vital signs were within her normal limits. The staff provided all care in her room and the plan of care was ongoing. An infection note dated 7/5/24 documented Resident #37 continued on isolation precautions for COVID-19. The resident denied pain at the time of the assessment and her vital signs were within her normal limits. The staff provided all care in her room, placed her call light within reach and the plan of care was ongoing. Another infection note dated 7/5/24 documented the resident continued on alert charting for isolation due to a positive COVID-19 test and all care was provided in her room. The resident's vital signs were within normal limits for the resident. Her vital signs were as follows: blood pressure 121/65, temperature 98.0 degrees Fahrenheit (F), pulse 99, respirations 20 and oxygen saturation 88 percent (%) on room air. A third infection note dated 7/5/24 documented the resident continued on alert charting because she was COVID-19 positive. Resident #37 was weak and on contact isolation precautions. When tolerated by the resident, fluids were offered by staff. The resident was on oxygen at 2 liters per minute (LPM) via nasal cannula and her oxygen saturation was 91%. The resident had an occasional moist cough. -There was no documentation to indicate the physician had been notified Resident #37 was now requiring oxygen and she was exhibiting a moist cough. Review of the July 2024 medication administration record (MAR) revealed Resident #37's morning medications were marked as not administered on 7/6/24 due to the resident appearing to be actively passing (dying). -However, the facility failed to obtain a physician's order to withhold or discontinue Resident #37's medications. An infection note dated 7/6/24 documented the resident continued on alert charting for isolation due to a positive COVID-19 test and all care was provided in her room. The resident's vital signs were within normal limits for the resident. Her vital signs were as follows: blood pressure 137/76, temperature 98.2 degrees Fahrenheit (F), pulse 105, respirations 25 and oxygen saturation 91% on 2 LPM of oxygen. A health status note dated 7/6/24 documented the licensed practical nurse (LPN) spoke to the resident's representative and asked if she wanted the facility to begin comfort medications. The resident's representative refused and requested Tylenol suppositories be given to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation to indicate the physician had been notified that Resident #37 was continuing to decline. another health status note dated 7/6/24 documented the LPN spoke to the resident's representative again and informed the representative it looked like Resident #37 was passing. -There was no documentation to indicate the physician had been notified that Resident #37 was continuing to decline. A third health status note dated 7/6/24 documented the registered nurse (RN) called the resident's representative and informed her the resident continued to decline. -There was no documentation to indicate the physician had been notified that Resident #37 was continuing to decline. Review of the July 2024 MAR revealed Resident #37's evening medications were marked as not administered on 7/6/24 due to the resident appearing to be actively passing. -However, the facility failed to obtain a physician's order to withhold or discontinue Resident #37's medications. Review of the July 2024 MAR revealed Resident #37's morning medications were marked as not administered on 7/7/24 due to the resident appearing to be actively passing. -However, the facility failed to obtain a physician's order to withhold or discontinue Resident #37's medications. An infection note dated 7/7/24 documented the resident was still on active charting due to a positive COVID-19 test. The LPN documented the resident was actively passing away at the time of the note and all care was being provided in her room. Another infection note dated 7/7/24 documented the resident was declining and mouth care was provided in her room. Repositioning and mouth care was provided every two hours and the resident was on scheduled Tylenol via suppository for comfort. -There was no documentation to indicate the physician had been notified that Resident #37 was continuing to decline. Review of the July 2024 MAR revealed Resident #37's evening medications were marked as not administered on 7/7/24 due to the resident appearing to be actively passing. -However, the facility failed to have a physician's order to withhold or discontinue Resident #37's medications. Review of the July 2024 MAR revealed Resident #37's morning medications were marked as not administered on 7/8/24 due to the resident appearing to be actively passing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility failed to have a physician's order to withhold or discontinue Resident #37's medications. An infection note dated 7/8/24 documented Resident #37 was actively passing away. Her oxygen saturation was 82% on 5 liters of oxygen and her heart rate was 128 beats per minute. -There was no documentation to indicate the physician had been notified that Resident #37 was actively passing away. A progress noted dated 7/8/24 at 10:20 a.m. documented Resident #37 passed away. C. Staff interviews Registered nurse (RN) #2 was interviewed on 8/29/24 at 12:25 p.m. RN #2 said when a medication was ordered and the resident was unable to take the medication, the nurse needed to continue calling the physician until a response was received. RN #2 said she would not have administered the Paxlovid to Resident #37 because it was a choking hazard for the resident to swallow it whole. She said she was not the nurse who took care of Resident #37 so she was not involved when the resident began to decline. RN #2 said if a resident was actively passing away, the nurse needed to call the physician and request an order to withhold or discontinue the resident's medications. RN #2 said a physician's order was needed to hold a resident's medications no matter what the reason was. The director of nursing (DON), infection preventionist (IP) and RDCS #1 were interviewed together on 8/29/24 at 3:47 p.m. RDCS #1 said the nurses were supposed to keep calling the physician until they received guidance or a physician's order. She said the nurse was able to call the facility's medical director if the resident's physician was unable to be reached. The DON said the staff should only withhold residents' medications with a physician's order. The DON said she was unable to explain why a physician's order was not obtained to discontinue Resident #37's medications. Resident #37's primary care physician (PCP) was interviewed on 8/29/24 at 5:35 p.m. The PCP said he received a message from the facility on 7/3/24 which informed him Resident #37 was positive with COVID-19. He said he was informed the resident was unable to take Paxlovid because it was unable to be crushed. He said he discontinued the order for Paxlovid. The PCP said if Resident #37 was unable to take the Paxlovid the facility could have sent her to the emergency room to receive intravenous (IV) Paxlovid but he said he did not recall staff requesting that. -However, review of Resident #37's EMR did not reveal a physician's order to discontinue the Paxlovid or documentation of further communication with the physician after the facility left a message with the PCP informing him Resident #37 could not take Paxlovid because it could not be crushed in order for the resident to swallow the medication (see record review above) The PCP said he was informed on 7/6/24 that Resident #37 appeared to be passing away and the nurses were withholding her medications. He said he usually sent orders for the medications to be discontinued but he was unable to locate the order and was unsure why he could not find the order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, review of Resident #37's EMR did not reveal further documentation to indicate the physician had been informed of the resident's continued decline (see record review above). 50314 IV. Resident #1 A. Resident status Resident #1, over the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 CPO, diagnoses included urinary incontinence, chronic kidney disease and chronic pain. The 8/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required maximum assistance with lower body dressing, toileting and bathing. The assessment documented Resident #1 had no rejections of care. B. Record review The bladder incontinence plan of care, initiated 2/28/24 and revised 8/12/24, revealed interventions including observing for urinary tract infection (UTI) symptoms, including pain, burning, blood tinged urine, cloudiness, dark urine color, no urine output, urinary frequency, foul-smelling urine, fever, chills, changes in behavior, or changes in eating patterns and reporting potential causes of incontinence, including bladder infections. A progress note dated 6/1/24 documented that nursing staff spoke to Resident #1's family members because the resident had experienced an open area on her skin in the perineal area (patch of skin between the anus and the genitals) and the resident appeared to need more assistance with perineal hygiene. A progress note dated 6/3/24 documented that Resident #1's urine culture had no growth in the first 48 hours. The progress note documented that the resident was experiencing several UTI symptoms, including burning and blood, protein and leukocytes (white blood cells) in urine. The progress note further documented the nurse spoke to medical doctor (MD) #1 who informed nursing staff to discuss the matter with MD #2. Nursing staff documented a message was left for MD #2. A fax order request/notification form was documented on 6/3/24 at 6:33 p.m. The fax order documented MD #2 was notified that Resident #1 continued to experience burning while voiding. The form requested a reply from MD #2. -However, review of Resident #1's EMR failed to reveal documentation to indicate MD #2 provided a response to the facility's request. -Additionally, Resident #1's EMR failed to reveal documentation to indicate the facility followed up again with MD #2 when they did not receive a response to their request or contact the medical director when MD #2 did not respond (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 6/6/24 documented that Resident #1 was experiencing pain with urination, and the resident's skin near the perineal area was excoriated. -Resident #1's EMR failed to reveal documentation to indicate the facility attempted to notify MD #2 again or contact the medical director when MD #2 did not respond. A progress note dated 6/8/24 documented Resident #1 continued to experience pain and burning with urination. The progress note documented a urine dipstick was collected and leukocytes, protein and blood were found in Resident #1's urine. The progress note documented the on-call physician was called four times that day (6/8/24) for nursing staff to obtain an order to send Resident #1's urine to the lab, however, the nursing staff was unable to reach the on-call physician. The progress note documented that nursing staff encouraged Resident #1 to drink water. -Review of Resident #1's EMR revealed there was no further documentation regarding the resident's UTI symptoms or follow-up with a physician from 6/8/24 until 7/6/24. A provider visit note dated 7/6/24 documented that Resident #1 had experienced UTIs chronically. The provider visit note documented Resident #1 reported urinary burning symptoms and the nursing staff reported that the resident had been complaining of burning upon urination. The provider note documented the resident's skin excoriation could also be a cause for the burning pain. -However, a urinalysis completed two days after this visit (on 7/8/24) documented the resident had two different types of bacteria present in her urinary tract (see final urinalysis results below). A progress note dated 7/8/24 documented a urinalysis was completed for Resident #1. The progress note documented the resident had many indications of a urinary tract infection, including an elevated white blood cell count, elevated leukocytes and the presence of mucus, bacteria and epithelial (skin) bacteria. A progress note dated 7/10/24 documented that Resident #1's urinalysis contained two separate bacterial colonies. These colonies included Klebsiella Pneumoniae and another unidentified bacteria. The progress note documented the results were faxed to MD #1. A progress note dated 7/11/24 documented that Resident #1's final urinalysis results were completed and the resident had a Klebsiella Pneumoniae infection and an Escherichia coli (E. coli) infection in her urine. The progress note documented that the results were reviewed by MD #3, who ordered an antibiotic. A review of the July 2024 revealed a physician's order for Cefpodoxime Proxetil (antibiotic) oral tablet 100 milligrams (mg), give 100 mg by mouth two times per day for UTI for 7 (seven) days, ordered 7/12/24 at 7:00 p.m. A progress note dated 7/13/24 documented that Resident #1 was started on antibiotic therapy on 7/13/24 for a UTI. -The facility failed to ensure appropriate physician follow-up was provided between 6/3/24 and 7/6/24 to appropriately address Resident #1's UTI symptoms in a timely manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interviews RN #1 was interviewed on 8/27/24 at 3:58 p.m. RN #1 said Resident #1 had experienced several infections in the last year . RN #1 said Resident #1's infections had mostly been UTIs and nursing staff knew to report the resident's symptoms to the physician when Resident #1 felt pain or burning with urination. Certified nurse aide (CNA) #1 was interviewed on 8/28/24 at 1:22 p.m. CNA #1 said Resident #1 required maximal assistance with toileting and perineal care. CNA #1 said Resident #1 had experienced several UTIs in the past year (2023 to 2024) and nursing staff was watching her closely for any signs or symptoms of UTIs. CNA #1 said Resident #1 had no rejections of care. The IP and the DON were interviewed together on 8/29/24 at 3:19 p.m. The IP said it was important for nursing staff to recognize signs and symptoms of infection and report them to the physician. The DON said she expected physicians and nursing staff to communicate when nursing staff identified new symptoms of infection in residents. The DON said the facility had experienced difficulties with physician communication and the facility was currently transitioning to work with a new group of physician partners in the future. The DON said she was unsure why it took more than a month for a provider to further investigate Resident #1's UTI symptoms.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one (#26) of one resident reviewed for hearing and vision problems out of 28 sample residents. Specifically, the facility failed to ensure Resident #26 was assisted to receive a replacement hearing aid after her right hearing aid was lost. Findings include: I. Resident #26 A. Resident status Resident #26, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included hearing loss of both ears, macular degeneration and anxiety disorder. The 6/10/24 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The assessment documented the resident had moderate difficulty hearing and required the use of hearing aides. B. Resident Observations On 8/26/24 at 3:51 p.m. Resident #26 was wearing one hearing aid in her left ear and no hearing aid in her right ear. On 8/27/24 at 9:41 Resident #26 was wearing one hearing aid in her left ear and no hearing aid in her right ear. On 8/28/24 at 1:44 p.m. Resident #26 was wearing one hearing aid in her left ear and no hearing aid in her right ear. C. Resident interview Resident #26 was interviewed on 8/26/24 at 3:51 p.m. Resident #26 said she only had one hearing aid in her left ear. Resident #26 said her right hearing aid was lost by the facility a long time ago. Resident #26 said the facility told her they would replace it but the facility never replaced it. Resident #26 said she had low vision and having low vision with one missing hearing aid made it very difficult for her to interact with other residents, family members and staff. Resident #26 said she was frustrated the facility had not assisted her in replacing her hearing aid. D. Record review (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility incident report form was provided by the nursing home administrator (NHA) on 8/27/24 at 3:11 p.m. The facility incident report form documented that Resident #26 reported her hearing aid was missing on 6/27/24 at 8:55 a.m. The incident report form documented that the facility would replace one lost hearing aid. The incident report form documented that this information was shared with Resident #26 on 8/8/24. -However, Resident #26 reported the facility had not replaced the hearing aid as of 8/26/24. (see interview above) A progress notes dated 8/29/24 (during the survey) documented a staff member spoke to the audiology clinic and Resident #26's hearing aid would be replaced. -However, the facility failed to attempt to replace the hearing aid for more than two months after it was reported missing. E. Staff Interviews The social service director (SSD) was interviewed on 8/27/24 at 1:25 p.m. The SSD said she was not involved in Resident #26's investigation concerning her hearing aid. The SSD said the NHA completed all investigations of missing property and would only involve the SSD upon request. The SSD said she did not know the current status of replacing Resident #26's hearing aid that was lost. The NHA was interviewed on 8/27/24 at 1:44 p.m. The NHA said Resident #26 was missing one hearing aid and the facility offered to replace it. The NHA said she completed the investigation into the hearing aid. The NHA said the hearing aid had not been replaced yet because the facility was experiencing logistical problems with reaching the audiology clinic. The NHA said she did not have documentation that the facility attempted to get Resident #26's hearing aid replaced. The NHA was interviewed again on 8/29/24 at 3:41 p.m. The NHA said the facility's transportation driver was able to get ahold of the audiology clinic today (8/29/24) to discuss replacing Resident #26's hearing aid. The NHA said the facility would implement a call log so the facility could document when calls were made to other care partners on behalf of resident care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure that residents who entered the facility without limited mobility and range of motion received appropriate services and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrated as unavoidable for one (#24) of four residents out of 28 sample residents. Specifically, the facility failed to ensure Resident #24 received passive range of motion (PROM) to prevent potential decline in her mobility. Findings include: I. Facility policy The Restorative policy, revised 8/7/21, was received on 8/28/24 at 5:44 p.m. from regional director of clinical services (RDCS) #2. It read in pertinent part, To promote the resident's optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring a resident's assessments and indicators. Nursing assistants must be trained in techniques that promote resident involvement in restorative activities. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities on activities of daily living do not diminish, this includes the facility ensuring that a resident is given the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living. A resident may be started on a restorative nursing program when he or she is admitted with restorative needs. Restorative nursing functions can be within one of the following categories: range of motion (active and passive), splint or brace assistance, bed mobility, transfers, walking, dressing and or grooming, eating and or swallowing, amputation/prosthesis care, communication, toileting program, bladder retraining. II. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dysphagia (difficulty swallowing), prediabetes and chronic kidney disease stage 3. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/5/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. The resident required substantial to maximum assistance with mobility and transfers. The MDS assessment revealed Resident #24 was not on a restorative program and was not receiving range of motion. B. Observations On 8/28/24 at 1:10 p.m. Resident #24 was transferred from the wheelchair to the shower chair with a hoyer mechanical lift. C. Resident representative interview The resident's representative was interviewed on 8/29/24 at 11:30 a.m. The representative said she had been asking for the resident to receive therapy and range of motion. She said Resident #24 had declined in her mobility. She said when the resident was admitted to the facility she was able to walk. The representative said the resident recently had a decline in mobility and was now being transferred from bed/wheelchair using a mechanical lift. The representative said she knew there had been some orders for therapy but she said she was never invited to come and be with the resident and encourage her participation in therapy when the therapists approached her. She said Resident #24 was responsive to her. D. Record review Resident #24's activities of daily living (ADL) care plan, updated 8/13/24, revealed the resident had a self-care performance deficit related to encephalopathy, weakness and cognitive deficits. The resident required extensive assistance of two staff members with personal hygiene. Pertinent interventions included having Resident #24 participate to the fullest extent possible with each interaction -The care plan did not indicate the resident was receiving range of motion exercises for her upper or lower extremities. The Kardex (tool utilized by staff to provide consistent resident care)dated 8/29/24 documented the resident required extensive assistance of one to two staff members for bed mobility. The Kardex directed extensive assistance by two staff members for transfers with a mechanical hoyer lift. A physical therapy (PT) note dated 4/30/24 documented PT services were offered but the resident said she wanted to wait until tomorrow. -The note failed to document if more than one attempt was made to offer the resident PT. A PT note dated 5/9/24 documented the resident was offered PT and the resident refused. -The note failed to document if more than one attempt was made to offer the resident PT. A nurse progress note dated 6/11/24 documented the resident was using the mechanical hoyer lift for transfers. The resident was no longer able to use the sit to stand lift for transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A therapy progress note, dated 8/8/24 and written by the director of rehabilitation (DOR), documented Resident #24 was offered therapy to improve her transfers but the resident said she wanted to sleep. -The note failed to document if more than one attempt was made to offer the resident therapy. -Review of Resident #24's electronic medical record (EMR) failed to reveal the resident had a restorative program plan which was individualized and included passive range of motion for both lower and upper bilateral extremities for her limited range of motion. -The EMR further revealed there were no baseline assessments of the resident's range of motion of either her upper and lower extremities. E. Staff interviews The director of nursing (DON) was interviewed on 8/29/24 at approximately 1:00 p.m. The DON said Resident #24 had had a decline in mobility and she was being transferred using a hoyer mechanical lift. She said the resident was not on a restorative program. She said that there was no PROM program for the resident because one would have to be written by the therapy program. She said the resident's arms were extended when she was dressed. The director of rehabilitation (DOR) was interviewed on 8/29/24 at 1:15 p.m. The DOR said Resident #24 was not on any restorative program. He said he could not develop a restorative program unless the resident was seen by a licensed therapist. He said the resident had declined therapy services in the past when they attempted. He said he had asked for the resident's representative to come to the facility when the resident was offered therapy and she had declined. -However, the representative said she had not been invited to come to the facility when the therapist approached the resident (see resident's representative interview above). -Additionally, there was no documentation in Resident #24's EMR to indicate the DOR had asked the resident's representative to come to the facility when the therapists attempted to provide therapy for the resident. -The DOR said the therapy department only did baseline assessments for range of motion on residents who had been on therapy services. He said he did not know who completed the baseline range of motion assessments for residents who were not on therapy services. The physical therapist assistant (PTA) was interviewed on 8/28/24 at 11:51 a.m. The PTA said the facility did not have a restorative program. Certified nurse aide (CNA) #6 was interviewed on 8/28/24 at 4:25 p.m. CNA #6 said the facility did not have a restorative program. She said there were no individual plans for PROM for residents. She said physical therapy worked with the residents. CNA #1 was interviewed on 8/28/24 at 4:28 p.m. CNA #1 said she did not know anything about a restorative program but did say that residents who went to activities would sometimes play with pool noodles for exercise. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7 was interviewed on 8/28/24 at 4:29 p.m. CNA #7 said she did not perform range of motion with residents. She said there were not any residents who had individualized restorative program plans. She said only therapy was involved with range of motion for residents. The director of nursing (DON) was interviewed on 8/28/24 at 4:41 p.m. The DON said the facility did not have a restorative program anymore. She said the facility would like to reinstate it at some time but the facility currently did not have enough staff to complete restorative programs.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observation, record review and interviews, the facility failed to ensure one (#24) of three residents reviewed for weight loss out of 28 sample residents received the care and services necessary to meet their nutrition and hydration needs and to maintain their highest level of physical well-being. Resident #24 was admitted on [DATE] with a diagnosis of Alzheimer's disease, dysphagia (difficulty swallowing), prediabetes and chronic kidney disease stage 3. On 7/16/24 the resident weighed 197 pounds (lbs) and on 8/29/24 the resident weighed 185 lbs. The resident lost 5.1% (10 lbs) of her body weight in 29 days. While nutritional interventions were initiated when a significant weight loss was identified on 7/12/24 (2 cal MedPass supplement), observations revealed the facility failed to promote the resident's nutritional status by encouraging, and providing meals and snacks, documenting her intake of meals accurately and monitoring weekly weights. Findings include: I. Facility policy and procedure The Weight policy, reviewed on 8/19/24 was provided by regional director of clinical services (RDCS) #2 on 8/29/24 at 2:35 p.m. It revealed in pertinent part, Following a routine weighing schedule helps detect weight changes. Unless otherwise specified, a resident's weight should be recorded at the time of admission, weekly for four weeks, and then monthly. A decrease in weight of 5% or more in a month or of more than 10% in 6 (six) months should be reported to the practitioner for further evaluation. II. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dysphagia, prediabetes and chronic kidney disease stage 3. According to the 8/5/24 minimum data set (MDS) assessment, the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. Resident #24 was independent with eating. She required partial/moderate assistance with oral hygiene and was dependent on staff for all other activities of daily living (ADL). The MDS assessment indicated the resident was prescribed a mechanically altered diet. The assessment indicated the resident did not have weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	B. Observations and staff interviews On 8/26/24 at approximately 12:15 p.m., the resident received her meal, which consisted of salisbury steak, mixed vegetables, sweet potatoes and cake. The resident consumed less than 25% of her meal, although an unidentified certified nurse aide (CNA) was assisting her. She was not offered an alternative when she ate less than 50% of the meal. The resident was administered the 2 cal MedPASS with the meal. -A review of the meal intake for 8/26/24 documented that she consumed 50%, however, the observation above revealed the resident consumed less than 25% of her meal. During a continuous observation of the dinner meal on 8/27/24, beginning at 3:00 p.m. and ending at 5:53 p. m., the following was observed: At 3:00 p.m. the resident was lying in bed with her eyes closed. At 5:08 p.m. the resident was lying in bed. The dinner meal service had begun. Residents who were eating in the dining room and in their rooms were receiving their meals. At 5:15 p.m. the resident continued lying in her bed. She had not been offered her dinner. She had not been offered to get up to go to the dining room. At 5:30 p.m. the resident continued to lie in bed. The staff had not offered a meal to her. At 5:45 p.m. the staff began to pick up meal trays from residents who were finished eating. There were no meal trays being passed to residents. At 5:53 p.m. the registered dietitian (RD) said the resident did not get a dinner meal, because it was discussed with the resident's family and she would not eat a dinner meal because she would rather sleep. She said that was the reason the resident did not get served a dinner meal. The RD said a snack was given to the resident at 3:00 p.m. She said it was a part of the resident's comprehensive care plan. -However, a continuous observation revealed that at 3:00 p.m., Resident #24 was lying in her bed with her eyes closed and no staff entered her room to offer her a snack from 3:00 p.m. until the continuous observation ended at 5:53 p.m. During a continuous observation on 8/28/24, beginning at 8:46 a.m. and ending at 12:26 p.m., the following was observed: At 8:46 a.m. the resident was assisted away from the dining room table. CNA #1 had assisted the resident with her meal. The resident consumed all of the scrambled eggs. She did not eat the oatmeal, ground sausage or the potatoes. At 8:55 a.m. the resident was sitting in her chair in her room. The resident was given a cookie and also a cup of hot cocoa. The resident ate all of the cookie and the hot cocoa. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 9:19 a.m. the environmental services director (ESD) was in the resident's room fixing the resident's television. The resident asked for something to eat. The ESD asked her if she wanted something to eat, and the resident responded yes, when you get a chance. -The ESD did not bring the resident anything to eat. At 9:23 a.m. the resident asked for a sandwich and she said she was hungry, CNA #4 said she had given her a cookie and a cup of hot chocolate a little bit ago. The resident said she was still hungry. CNA #4 said she would bring her some fruit. At 9:49 a.m. the resident was sleeping in her chair. -CNA #4 did not get the resident anything to eat. At 9:51 a.m. the resident continued to stay in her room. -She had not received anything else to eat as CNA #4 had said she would. At 11:05 a.m. CNA #4 asked the resident to go to trivia. -CNA #4 did not offer the resident a snack or provide the snack which the resident had requested nearly two hours earlier. At the activity, the resident did not receive any snacks. At approximately 12:01 p.m. the resident received her meal. CNA #5 assisted the resident with the meal. At approximately 12:10 p.m. the resident began to feed herself. At 12:26 p.m. the resident was assisted from the dining room to her room. The resident ate less than 25% of her meal and 25% of her Magic Cup (nutritional dessert cup). C. Resident's representative interview The resident's representative was interviewed on 8/29/24 at 11:30 a.m. The resident's representative said she was not aware that the resident had lost weight. She said she had requested the resident to eat in the dining room at each meal, as she ate better when she was upright and at a table. The resident's representative said she did not agree to the resident skipping the dinner meal. D. Record Review The nutrition care plan, updated on 3/18/24, revealed the resident was at risk for malnutrition related to dementia and limited mobility as evidenced by the medical record, preference of MM5 (diet minced and moist) texture and preferences to sleep through dinner nightly. Pertinent interventions included cueing and orienting the resident to food, offering her a few bites of complete assistance and then she was able to continue eating independently, offering snacks and fluids at activities and hours of sleep, observing and reporting signs of malnutrition and offering healthier options when offering snacks. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The August 2024 CPO revealed the resident had the following physician's orders related to nutrition: 2 cal MedPass (nutritional supplement) 120 milliliters (ml) two times a day, ordered 7/12/24 with the associated diagnosis of weight loss, ordered 7/12/24. Snack at bedtime, ordered 11/8/21. A review of the August 2024 (8/1/24 to 8/29/24) medication administration record (MAR) revealed the resident was consuming 100% of the 2 cal MedPass two times a day. -A review of the August 2024 MAR revealed a bedtime snack was consumed zero times from 8/1/24 to 8/29/24. Resident #24's weights were documented in the resident's electronic medical record (EMR) as follows: -On 5/1/24, the resident weighed 200 lbs; -On 6/12/24, the resident weighed 198 lbs; -On 7/16/24, the resident weighed 197 lbs; -On 8/7/24, the resident weighed 184 lbs; -On 8/15/24, the resident weighed 187 lbs; and, -On 8/29/24, the resident weighed 185 lbs. -The resident lost 10 lbs (5.08%) from 7/16/24 to 8/15/24, in 29 days, which was considered severe. The 7/12/24 nutrition note revealed the resident was discussed in a resident at risk (RAR) meeting. The resident's intake was poor and she refused food. She had a significant weight loss of 9.8% since 6/12/24. The committee recommended weekly weights, one to one feeding assistance as accepted and a trial for med pass (nutritional supplement) twice a day. The note documented the resident liked hot chocolate. The 8/16/24 nutrition note revealed the resident was reviewed in RAR. The resident had a 5% change in her weight over 30 days. The team recommended a Magic Cup, fruit smoothies with mighty shake and frozen berries. -However, a review of the resident's EMR did not reveal a physician's order for Magic Cup or fruit smoothies (see record review above). The 8/23/24 nutrition dietary note documented the resident was discussed in a RAR meeting with the interdisciplinary team. The resident's weight was slightly trending back up and was no longer a significant loss. Monthly weights were resumed and twice daily MedPass and Magic Cup continued. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The EMR revealed the resident was diagnosed with COVID-19 on 6/29/24 and was in isolation until 7/11/24. Although the resident was in isolation until 7/11/24, the weekly weights, which were recommended in the RAR meeting, were not completed after her time in isolation. -The RAR committee recommended the resident to be weighed weekly on 7/12/24. However, the facility did not weigh the resident weekly consistently. III. Staff interviews The RD and the clinical reimbursement specialist (CRS) were interviewed together on 8/29/24 at 12:10 p.m. The RD said the resident was reviewed in the RAR meeting weekly. She said the RAR meeting was used to analyze how the resident's nutritional needs were being met. She said the resident's representative was notified of the resident's weight loss. She said it was discussed with the representative that the resident would not receive a dinner meal, as she preferred to sleep. She said in regards to not offering the resident dinner , she could have done a better job documenting the conversation She said there was not a physician's order for the resident to receive a 3:00 p.m. snack and the MAR showed that she did not consume a bedtime snack. The RD said the resident had a significant weight loss and the resident's intake had been poor since July 2024. She said the 2 cal MedPass was added twice daily, which she consumed on a regular basis. She said the 2 cal MedPass should not be given with meals because it would fill the resident up with supplement and not food. The RD said the resident's weekly weights were discussed in RAR. She said however, because the resident was in isolation until 7/11/24, the weekly weights could not be completed. She said the weekly weights were not resumed after the isolation and not completed. The RD said the resident received a Magic Cup at lunch and breakfast. She said there was no documentation of the Magic Cup being provided to the resident. The director of nursing (DON) was interviewed on 8/29/24 at p.m. The DON said the resident had a physician's order for a peanut butter and jelly sandwich, however, this was related to the resident having a minced and moist texture. The DON said there was no documentation on the resident receiving a peanut butter and jelly sandwich as snack.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure that three (#16, #14 and #17) of three residents out of 28 sample residents received necessary respiratory care. Specifically, the facility failed to: -Ensure portable oxygen tanks were refilled timely for Residents #16, #14, and #17; -Ensure oxygen tubing was changed routinely and dated; and, -Ensure staff were using the appropriate personal protective equipment (PPE) while filling residents' oxygen tanks. Findings include: I. Facility policy and procedure The Oxygen Administration policy and procedure, revised on 2/27/24, was received from the regional vice president (RVP) on 8/29/24 at 6:50 p.m. It read in pertinent part, To assure that oxygen is administered and stored safely within the healthcare centers or in an outside storage area. Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with resident name and dated when setup or changed out. Cryogenic (relating to or involving very low temperatures) safety gear (face shield, gloves, apron) are required in the oxygen filling room for staff to use when filling portable units. II. Failure to ensure portable oxygen tanks were filled timely and oxygen tubing was changed routinely and dated A. Resident #16 1. Resident status Resident #16, age 79, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis) and hemiparesis (muscle weakness or partial paralysis) following cerebral infarction (stroke) affecting left non-dominant side, vascular dementia with psychotic disturbance. The 6/25/24 minimum data set (MDS) assessment revealed Resident #16 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She had limited range of motion on one side of her upper extremity and both sides of her lower extremities. The resident was dependent on staff assistance for bed mobility, transfers and most of her activities of daily living (ADL). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment indicated the resident was receiving oxygen therapy. 2. Observations On 8/27/24 at 3:15 p.m. Resident #16 was in her room and was using her portable oxygen tank. -There was no date labeled on her oxygen tubing. On 8/27/24 at 6:02 p.m., the resident's portable oxygen tank was observed with certified nurse aide (CNA) #5. -The nasal cannula was in the resident's nose, however, the portable oxygen tank hanging on the resident's wheelchair was empty. CNA #5 took the resident's portable oxygen tank to go fill it in the oxygen room. 3. Record review Review of the August 2024 CPO revealed the following physician's order for oxygen: Oxygen at 2 liters per minute (LPM) to keep saturations (level of oxygen in the blood) at 90% (percent) or above, ordered 8/26/24. Resident #16's respiratory care plan, updated 3/18/24, revealed the resident was on 2 LPM of oxygen via nasal cannula as needed. Pertinent interventions included tracking the resident's oxygen levels daily. -Review of the August 2024 treatment administration record (TAR) failed to show Resident #16's oxygen tubing was changed. B. Resident #14 1. Resident status Resident #14 age 90, was admitted on [DATE]. According to the August 2024 CPO diagnoses included chronic obstructive pulmonary disease (COPD), altered mental status and stroke. The 6/7/24 MDS assessment revealed Resident #14 had severe cognitive impairments with a BIMS score of four out of 15 The assessment indicated the resident was receiving oxygen therapy. 2. Observations On 8/27/24 at approximately 5:50 p.m. Resident #14, who had been observed at various activities throughout the day, was sitting in the hallway. He had his nasal cannula in his nose and his portable oxygen tank was hanging on the back of his wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no date labeled on his oxygen tubing. The resident's portable oxygen tank was observed with CNA #5. -The portable oxygen tank was empty. CNA #5 took the resident's portable oxygen tank and went to fill it in the oxygen room. 3. Record review Review of the August 2024 CPO revealed the following physician's order for oxygen: Oxygen at 1 to 3 LPM to keep saturations at 90% or above, ordered 3/4/24. Resident #14's respiratory care plan, updated 3/18/24 revealed the resident was to be on 1 to 3 LPM of oxygen and needed to have oxygen levels monitored each shift to maintain oxygen levels of 90% or greater. Pertinent interventions included monitoring the resident's oxygen levels daily and changing out the oxygen tubing every Sunday during the night shift. C. Resident #17 1. Resident Status Resident #17, age 86, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included unspecified dementia, adult failure to thrive, heart failure unspecified and shortness of breath. The 6/3/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of eight out of 15. The MDS assessment revealed the resident was on oxygen therapy and required moderate assistance with bathing and dressing and needed maximal assistance with toileting. 2. Observations On 8/27/24 at 6:02 p.m. Resident #17 was in the dining room with her nasal cannula in her nose and her portable oxygen tank on the back of her wheelchair. -There was no date labeled on her oxygen tubing. The portable oxygen tank was observed with the infection control preventionist (IP). -The resident's portable oxygen tank was empty. The IP filled the tank. The IP took the resident's portable oxygen tank and went to fill it the oxygen room. 3. Record Review Review of the August 2024 CPO revealed the following physician's order for oxygen: Oxygen at 2 LPM via nasal cannula for shortness of breath, ordered 8/13/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17's respiratory care plan, updated 3/6/24, revealed the resident was to be on 1 to 2 LPM of oxygen as needed for disorientation. Pertinent interventions included changing the oxygen tubing every Sunday during the night shift. D. Staff interviews CNA #5 was interviewed on 8/27/24 at 5:45 p.m. CNA #5 said the residents' portable oxygen tanks were checked on the night shift and after lunch. -However, observations of Resident #16's, #14's and #17's oxygen tanks following CNA #5's interview revealed all three residents' portable oxygen tanks were empty (see observations above). The director of nursing (DON) was interviewed on 8/27/24 at 6:15 p.m. The DON said portable oxygen tanks were to be checked every two hours. She said the tanks should also be checked prior to meals or if the resident was on the portable tanks for an extended period of time. The DON was interviewed a second time on 8/29/24 at approximately 4:00 p.m. The DON said she provided education (during the survey) to the certified nurse aides during the CNA huddles. She said the education included checking the portable oxygen tanks every couple of hours, before meals and when residents were brought out of their rooms for activities. III. Failure to wear appropriate PPE while filling residents' oxygen tanks A. Observations The facility's oxygen room was located on the Brother Ben's hallway. The oxygen room had three liquid oxygen tanks. The PPE staff was supposed to use to fill the portable oxygen tanks was hanging on the wall just inside the room. The PPE provided included a pair of goggles, heavy gloves that went to the elbows, ear protection and a heavy yellow apron. On 8/27/24 at approximately 6:15 p.m. three different employees, CNA #5, IP, and the NHA were observed filling portable oxygen tanks. The NHA was wearing the appropriate PPE provided for safety. -CNA #5 and the IP failed to use the appropriate PPE while filling portable oxygen tanks. The DON) was interviewed on 8/29/24 at approximately 4:00 p.m. The DON said proper PPE needed to be worn when filling the portable oxygen tanks for the safety of the staff. She said the appropriate PPE included an apron, eye protection and heavy gloves.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50314 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for one out of five staff reviewed. Specifically, the facility did not complete an annual performance review and/or provide regular in-service education based on the outcome of the review for certified nurse aide (CNA) #2. Findings include: I. Record review CNA #2 (hired on 6/22/22) did not have an annual performance review completed. CNA #2 did not have an in-service education plan based on the outcome of the review. II. Staff interviews The nursing home administrator (NHA) was interviewed on 8/29/24 at 10:11 a.m. The NHA said she completed performance evaluations for CNAs in the facility. The NHA said CNA #2 had been out of the country between January 2024 and April 2024 and was currently a PRN (as needed) employee. The NHA said CNA #2 had worked in the facility in April 2024 after returning to the United States on 4/19/24. The NHA said CNA #2 had not had a performance evaluation or in-service education based on the outcome of that review. The NHA said she would do monthly audits moving forward to ensure all CNAs in the facility received timely annual evaluations.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50314 Based on observations, record review and interviews, the facility failed to ensure staffing information was posted in a prominent place, readily accessible to residents and visitors. Specifically, the facility failed to post the total number of actual hours worked by the licensed and unlicensed staff directly responsible for resident care per shift. Findings include: I. Observations Observations in the facility on 8/26/24 at 8:38 a.m. revealed the staff posting was dated 7/18/24. The posting was located near the main nurse's station outside of the dining room. Observations in the facility on 8/26/24 at 11:07 a.m. revealed the staff posting was dated 7/18/24. The posting was located near the main nurse's station outside of the dining room. II. Staff interview The director of nursing (DON) was interviewed on 8/26/24 at 11:10 a.m. The DON said the current staffing posted was dated 7/18/24. The DON said the central supply staff member was responsible for posting the updated nurse staff posting in the facility. The DON said the central supply staff member who normally updated nurse staff posting was on vacation and that the staff posting had not been updated in the facility after 7/18/24. The DON said it was important to have updated staffing posted so visitors, residents and other staff members knew how many staff members were working in the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure that one (#241) of five residents out of 28 sample residents were free from unnecessary medications. Specifically, the facility failed to ensure as needed (PRN) physician's orders for psychotropic drugs were limited to 14 days unless the physician provided a rationale for extended use. Findings include: I. Resident #241 A. Resident Status Resident #241, age 79, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of left femur (break in the femur), unspecified dementia, severe, unspecified osteoarthritis (arthritis) and history of falling. The 7/5/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required setup and clean up assistance for meals, partial assistance with bathing, toileting and upper body dressing and needed substantial assistance with lower body dressing. B. Observations On 8/26/24 at 10:09 a.m. Resident #241 was heard calling out, Please help me. On 8/27/24 during a continuous observation, beginning at 12:41 p.m. and ending at 3:18 p.m., the resident did not exhibit any behaviors or calling out. On 8/28/24 at 9:01 a.m. Resident #241 was heard calling out, I have to go to the bathroom, I can't do this, oh dear God please help me, this is too much! An unidentified certified nurse aide (CNA) walked by but did not check on the resident. On 8/28/24 at 9:05 a.m. the resident stopped calling out. On 8/28/24 at 9:22 a.m. the resident was heard calling out, Please help, I can't do this anymore, please don't ignore me! An unidentified CNA and nurse went into her room and closed the door. C. Record review (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #241's comprehensive care plan, initiated 7/15/24, revealed a care plan focus area for the use of anti-anxiety medications. Pertinent interventions included administering anti-anxiety medications as ordered by the physician, monitoring/documenting side effects and effectiveness of the medication every shift, monitoring/documenting/reporting as needed any adverse reactions to anti-anxiety therapy, changes in behavior/mood/cognition and hallucinations/delusions. The August 2024 CPO revealed the following physician's order for Lorazepam: Lorazepam oral concentrate 2 milligrams (mg)/milliliter (ml) every eight hours as needed for anxiety until 11/1/24, ordered 8/27/24. Review of Resident #241's electronic medical record (EMR) failed to reveal documentation for physician's rationale for the extended use of the PRN lorazepam beyond 14 days. II. Staff interview The director of nursing (DON) was interviewed on 8/29/24 at p.m. The DON said she was aware PRN psychotropic drugs were to not be given past 14 days without a documented physician's rationale. She said she was not aware there was no rationale documented by the physician for the extended use of Resident #241's PRN lorazepam.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48412 Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable in taste, texture, appearance and temperature. Specifically, the facility failed to ensure food was palatable and served at the appropriate temperature. Findings include: I. Resident interviews Resident #12 was interviewed on 8/26/24 at 10:44 a.m. Resident #12 said she ate her meals in the dining room and had received cold food several times. She said she did not eat meat and the vegetables were overcooked or undercooked and the food was bland. Resident #30 was interviewed on 8/26/24 at 2:00 p.m. Resident #30 said she ate her meals in her room and her food was often served at a lukewarm temperature or cold. She said her food was edible but never arrived in her room hot. Resident #1 was interviewed on 8/26/24 at 2:48 p.m. Resident #1 said she ate her meals in her room and received cold food on her room tray. II. Resident group interview The resident group was interviewed on 8/28/24 at 2:07 p.m. with Resident #23, Resident #30, Resident #31, Resident #26, Resident #1, Resident #32, Resident #12 and Resident #5. The residents were identified as alert and oriented through facility and assessment. Resident #26 said she received cold food at meal times. Resident #23 said he received cold food at meal times. Resident #5 said she received cold food at meal times. III. Observations A test tray for a regular diet was evaluated by four surveyors immediately after the last resident had been served dinner on 8/28/24 at 5:34 p.m. The test tray consisted of parmesan crusted tilapia, tartar sauce, pea salad, dinner roll and corn kernels. -The parmesan crusted tilapia was 111.8 degrees Fahrenheit (F) and tasted bland; -The pea salad was 64.5 degrees F and had a strong onion taste; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The corn was 122.3 degrees F, was tough, greasy and tasted like oil; and, -The tartar sauce was 70.3 degrees F and was acidic. IV. Resident council notes The 6/12/24 resident council notes revealed a resident requested to have her meals served warmer. -There was no documentation indicating how the facility took steps to address the resident's request of wanting warmer food. V. Staff interviews The registered dietitian (RD), the nursing home administrator (NHA) and the regional vice president (RVP) were interviewed together on 8/29/24 at 10:37 a.m The RD said the residents had not informed her that the meals were not served at the correct temperature or that the food did not taste good. The RD said cold foods were on ice during service and served at 41 degrees F. The RD said hot foods were served between 120 degrees F and 145 degrees F after the initial cooking temperature was reached. The NHA said she had not heard anything from the residents regarding the temperatures or taste. The NHA said the residents wanted to have food committee meetings during resident council meetings and the facility planned to combine the meetings in September 2024. The RVP said the facility was going to take a look at what was going on with the temperatures and taste of the food. The RD said it was important to serve food at the correct temperature and hot so the meal was enjoyable and safe to eat.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48412 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure a dietary aide's (DA) medication was not stored in the walk-in refrigerator; -Ensure appropriate hand hygiene was performed for staff and residents during meal service; and, -Ensure dietary staff removed their jewelry before serving meals. Findings include: I. Failure to ensure staff medications were not stored in the walk-in refrigerator A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, was retrieved on 9/6/24 from https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, revealed in pertinent part, Medicines belonging to employees that require refrigeration and are stored in a food refrigerator shall be stored in a package or container and kept inside a covered, leakproof container that is identified as a container for the storage of medicines. B. Observations and staff interviews During the initial tour of the kitchen on 8/26/24 at 9:32 a.m. the walk-in refrigerator had a gallon plastic bag on the top shelf next to the resident's food. The bag was marked with cook (CK) #2's name. Inside the plastic bag was an insulin pen. At 9:48 a.m. CK #2 said the insulin pen was his and he sometimes placed the insulin pen in the walk-in refrigerator. At 9:49 a.m., the registered dietitian (RD) said the employees were not supposed to store personal medications in the walk-in refrigerator. The RD said the insulin pen needed to be moved to the employee refrigerator. C. Additional staff interview The nursing home administrator (NHA), the RD and the regional registered dietitian (RDD) were interviewed together on 8/28/24 at 1:55 p.m. The RD said she provided education to the kitchen staff about personal belongings and personal medications being stored in the walk-in refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Facility follow-up The nutritional services huddle, completed on 8/28/24 (during the survey), was provided by the RD on 8/28/24 at 1:00 p.m. It read in pertinent part, All personal items must be kept in the employee refrigerator in the employee break room or in the employee closet. No food, drinks or medications can be stored in the refrigerator in the kitchen. II. Failure to ensure hand hygiene was conducted appropriately in the dining room A. Professional reference According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations, retrieved on 9/6/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, 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; after handling soiled equipment or utensils; 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 policy, reviewed on 5/29/24, was provided by the regional vice president (RVP) on 8/29/24 at 6:44 p.m. It read in pertinent part, The hands are the conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to a patient and from a staff member to a patient. Because of this, hand hygiene is the single most important procedure to prevent infection. To protect patients from healthcare-associated infection, hand hygiene must be performed routinely and thoroughly. The Centers for Disease Control and Prevention (CDC) recommends performing hand hygiene with soap and water before eating. Teach patients and their families about the importance of hand hygiene in preventing the spread of infection. C. Observations During a continuous observation on 8/26/24, beginning at 11:30 a.m. and ending at 12:49 p.m., the following was observed: At 11:49 a.m. an unidentified resident completed an activity and was immediately brought into the dining room. An unidentified staff member assisted the resident into the dining room and did not offer hand hygiene to the resident. The resident ate her entire meal with her hands after throwing balls with other residents and sharing pool noodles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:50 a.m. an unidentified resident had completed an activity throwing balls with other residents and sharing pool noodles. The resident wheeled himself from the activity to the hallway and touched his wheels. Hand hygiene was not offered to the resident and the resident ate his lunch with his hands. At 11:57 p.m. an unidentified DA served residents their drinks in the dining room. The DA did not complete hand hygiene in between handing out drinks, touching residents and touching resident's wheelchairs. During a continuous observation on 8/27/24, beginning at 4:50 p.m. and ending at 5:43 p.m., the following was observed: At 4:50 p.m. hand hygiene was only offered to the residents at the assistance table. Approximately five independent residents entered the dining room via their personal walkers and three independent residents self-propelled in their wheelchairs. Hand hygiene was not offered to the residents once they were seated. At 5:43 p.m. an unidentified resident was assisted from his room to the dining room and was not offered hand hygiene. The resident ate a tuna salad sandwich and potato chips with his hands. During a continuous observation on 8/28/24, beginning at 11:29 a.m. and ending at 12:46 p.m., the following was observed: At 11:51 a.m. an unidentified DA served drinks to the residents in the dining room. The DA did not complete hand hygiene in between handing out drinks, touching residents and touching resident's wheelchairs. At 12:00 p.m. an unidentified resident was sitting at a dining room table and not offered hand hygiene. The resident rearranged fake flowers that sat on the table then ate her food with her hands. D. Staff interview The RD was interviewed on 8/29/24 at 10:37 a.m. The RD said she was concerned with making sure hand hygiene was offered to the residents who ate in their rooms and she did not realize the residents in the dining room were not being offered hand hygiene. The RD said the DA needed to complete hand hygiene after she touched anything other than the clean drink she was handing out. III. Failure to ensure dietary staff did not wear jewelry while preparing food A. Professional reference According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations, retrieved on 9/6/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view revealed in pertinent part, Except for a plain ring, such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations During a continuous observation of the dinner service on 8/28/24, beginning at 4:30 p.m. and ending at 5:34 p.m., the following was observed: At 4:30 p.m. DA #2 was wearing a corded bracelet on her left wrist with strings hanging from the bracelet. At 4:44 p.m. DA #2 opened individual packets of butter and placed them on the tray line. DA #2 grabbed a butter packet and the strings to her bracelet dragged through other opened packets of butter. At 4:53 p.m. DA #2 grabbed another packet of butter and the strings to her bracelet drug through the other opened butter. She placed the butter packet on a plate and the strings of her bracelet dragged across the food she was plating for a resident. At 5:13 p.m. DA #2 reached over to grab an individual container of ketchup on the service line and the strings of her bracelet drug through the opened butter containers. C. Staff interviews The RVP was interviewed on 8/29/24 at 1:00 p.m. The RVP said staff were not allowed to wear jewelry in the kitchen and she was unaware it was occurring. The RVP said education was going to be provided to the dietary staff.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48412 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address multiple concerns related to quality of care. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) Plan, revised 1/18/24, was provided by the nursing home administrator (NHA) on 8/26/24 at 1:00 p.m. It read in pertinent part, The QAPI Program is to utilize an ongoing, data-driven, proactive approach to advance the quality of life and quality of care for all residents at the facility. All facility associates, families and residents will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and provide ongoing feedback. The facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act cycle of improvement to prevent recurrences. II. Cross-referenced citations Cross-reference F550 dignity: The facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Cross-reference F655 baseline care plans: The facility failed to develop and implement acute/baseline care plans. Cross-reference F677 activities of daily living for dependent residents: The facility failed to provide appropriate treatment and services to maintain or improve residents' ability to perform activities of daily living. Cross-reference F688 range of motion: The facility failed to ensure residents with limited mobility reviewed for range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F692 nutrition and hydration: The facility failed to ensure effective interventions were in place to address weight loss timely. Cross-reference F695 respiratory: The facility failed to ensure residents received proper respiratory treatment and care. Cross-reference F880 infection control: The facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection. Cross-reference F758 unnecessary psychotropic medications: The facility failed to ensure residents were as free from unnecessary psychotropic drugs as possible. Cross-reference F684 quality of care: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. Cross-reference F685 treatment or devices to maintain hearing and vision: The facility failed to ensure proper treatment and services to maintain hearing. Cross-reference F645 Preadmission Screening and Resident Review (PASRR) Level I: The facility failed to ensure a PASRR Level I screening was completed within thirty days of admission. Cross-reference F804 palatable food: The facility failed to ensure residents were provided with food cooked and served in a manner that conserved nutritive value, flavor, appearance, texture and at an appetizing temperature. Cross-reference F812 kitchen sanitation: The facility failed to prepare and serve food in a sanitary manner. III. Staff interviews The nursing home administrator (NHA) and regional vice president (RVP) were interviewed together on 8/29/24 at 7:43 p.m. The NHA said the facility did not invite floor staff, residents or family members to their QAPI meetings or for feedback but the facility wanted to. She said the facility had not accomplished getting others involved in the QAPI meetings. The NHA said dignity, baseline care plans, positioning residents, restorative services, weight loss, oxygen canisters, as-needed psychotropic medications, PASRR Level I screens, palatable food and kitchen sanitation were not identified by the QAPI team as areas for improvement. The NHA said hand hygiene and infection control were always watched as an area for improvement but resident hand hygiene and appropriate cleaning of resident rooms were not identified as an area for improvement until the annual recertification survey. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the QAPI team needed to create a performance improvement plan (PIP) and complete audits to better identify areas for improvement. The NHA said the facility completed random spot checks with staff and she wanted to increase spot checks. She said the facility needed more eyes on the floor to identify areas for improvement. She said the facility focused on bigger areas of concern for improvement and the little areas were missed. The NHA said there was a lot of turnover in leadership which caused a breakdown in the system. She said the QAPI system worked but the QAPI team needed to re-evaluate, not just focusing on the bigger areas of concern but all areas that could affect the care the facility provided the residents.

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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** 50314 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 high touch areas in residents' rooms; and, -Ensure staff followed appropriate hand hygiene practices. Findings include: I. Housekeeping failures A. Professional reference The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (3/19/24) was retrieved on 9/5/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-c.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. 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. B. Facility policy The Daily Room Cleaning policy, reviewed 6/12/24, was received from the regional director of clinical services (RDCS) #1 on 8/29/24 at 2:10 p.m. It read in pertinent part, The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The policy did not specify that high touch surface areas should be cleaned C. Observations On 8/27/24 at 8:37 a.m. housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER]. -The call light cords in the resident's room and the resident's bathroom were not cleaned by HSKP #1 during the room cleaning process. -the door handles to the resident's room and the resident's bathroom were not cleaned by HSKP #1 during the room cleaning process. On 8/29/24 at 9:14 a.m. HSKP #2 was observed cleaning room [ROOM NUMBER]. -The call light cords in the resident's room and the resident's bathroom were not cleaned by HSKP #2 during the room cleaning process. -The door handles to the resident's room and the resident's bathroom were not cleaned by HSKP #2 during the room cleaning process. D. Staff interviews HSKP #1 was interviewed on 8/27/24 at 8:55 a.m. HSKP #1 said call light cords and door handles should be cleaned daily because they were high touch surfaces. HSKP #1 said she cleaned the call light cords during the room cleaning she completed in room [ROOM NUMBER]. -However, HSKP #1 failed to clean either residents' call light, the bathroom call light or the door handles to the room or the bathroom in room [ROOM NUMBER] (see observation above). -Additionally, the director of housekeeping (DHK) said HSKP #1 reported to her she had not cleaned the resident call lights during the room cleaning in room [ROOM NUMBER] on 8/27/24 (see DHK interview below). HSKP #2 was interviewed on 8/29/24 at 9:35 a.m., utilizing a spanish-speaking interpreter. HSKP #2 said she did not clean the residents' call lights , the call light in the bathroom or the room and bathroom door knobs in room [ROOM NUMBER]. The DHK was interviewed on 8/29/24 at 12:40 p.m. The DHK said call light cords, door handles, drawer handles and cabinet handles were high-touch surface areas that should be cleaned everyday. The DHK said she had previously spoken to housekeeping staff about the importance of cleaning high-touch surfaces as part of the daily cleaning. The DHK said HSKP #1 told her she did not clean the resident's call light cords or the call light cord in the bathroom during the room cleaning observation that occurred on 8/27/24 in room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 8/29/24 at 3:19 p.m. The IP said the resident call lights and door handles should be cleaned because they were considered high touch surfaces that could transmit infections. The IP said resident call light cords and door handles should be cleaned every day. The DON said call lights and door handles should be cleaned daily. II. Hand hygiene failures A. Professional reference The CDC Clinical Safety: Hand Hygiene for Healthcare Workers, (2/27/24) was retrieved on 9/5/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands by handwashing with water and soap (plain soap or with an antiseptic), using an antiseptic hand rub (alcohol-based foam or gel hand sanitizer), or performing surgical hand antisepsis. Cleaning your hands reduces the potential spread of deadly germs to patients, the spread of germs, including those resistant to antibiotics, and the risk of healthcare personnel colonization or infection caused by germs received from the patient. Some healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep themselves, patients and staff safe. B. Facility policy The Hand Hygiene policy, reviewed 8/19/24, was received from the regional vice president (RVP) on 8/29/24 at 6:49 p.m. It read in pertinent part, Hand hygiene using an alcohol-based hand rub is appropriate before direct patient contact and after contact with inanimate objects in the patient's environment. C. Observations On 8/28/24 at 9:49 a.m, registered nurse (RN) #1 entered room [ROOM NUMBER]. RN #1 knocked on the door, opened the door and touched the resident's call light in the room. RN #1 left the room and began to prepare medications for another resident at the medication cart. -RN #1 failed to perform hand hygiene before entering room [ROOM NUMBER]. -RN #1 failed to perform hand hygiene after interacting with the resident's environment in room [ROOM NUMBER]. On 8/28/24 at 10:45 a.m., certified nurse aide (CNA) #1 was observed assisting Resident #33 to the restroom. -CNA #1 failed to offer Resident #33 hand hygiene after assisting her in the bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 10:31 a.m., CNA #2 was passing clean water cups to residents in their rooms. CNA #2 entered several residents' rooms and replaced the residents' used water cups with clean cups. CNA #2 performed hand hygiene after passing clean water to several rooms. -However, CNA #2 failed to perform hand hygiene before entering and after exiting each residents' rooms. -CNA #2 failed to perform hand hygiene after her hands became contaminated by touching used resident water cups. D. Staff interviews The IP and the DON were interviewed together a second time on 8/29/24 at 3:19 p.m. The IP said staff should perform hand hygiene before entering a resident's room, when they were leaving a resident's room and in between cares in the resident's room as appropriate. The IP said staff should offer to wash a resident's hands after assisting the resident to the bathroom. The IP said staff should wash their hands after interacting with a resident's environment in their room. The DON said nursing staff should offer hand hygiene to residents after they were assisted to the bathroom for toileting. The IP said it was important to promote hand hygiene to prevent the spread of infection in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065237	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Care Center	1200 Village Rd Carbondale, CO 81623

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50314 Based on interviews and record review, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for two out of five certified nurse aides (CNA) reviewed. Specifically, the facility failed to ensure CNA #2 and CNA #3 received 12 hours of continuing education annually. Findings include: I. Training record review Five randomly selected CNA training records were reviewed on 8/27/24. Of the five CNAs reviewed, CNA #2 and CNA #3 did not receive 12 hours of annual training. A. CNA #2 -CNA #2, hired on 6/22/22, had participated in 10 hours and 30 minutes of training during the annual training year. B. CNA #3 -CNA #3, hired on 6/11/14, had participated in 10 hours and 30 minutes of training during the annual training year. II. Staff interviews The nursing home administrator (NHA) was interviewed on 8/28/24 at 11:27 a.m. The NHA said she kept the records for the annual staff training and verified that all of the staff members received appropriate training in the facility. The NHA said she had recorded 10.5 hours of CNA training for CNA #2 and CNA #3, which also included dementia and abuse training. The NHA said it was important for CNAs to complete their annual training to stay updated on current bedside skills and education. The NHA said she would conduct an audit in the facility to ensure all staff had completed training appropriately moving forward.