STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Brookshire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4660 E Asbury Cir Denver, CO 80222	

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to ensure one (#47) of five residents out of 30 sample residents had the right to be informed of and participate in their treatment,the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that would furnish care, the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Specifically, the facility failed to obtain a consent from Resident #47 or their legal representative for the use of an antipsychotic medication before its administration. Findings include: I. Facility policy and procedure The Psychoactive/Psychotropic Medication Use policy, dated May 2024, was provided by the nursing home administrator (NHA) on 1/21/25 at 11:31 a.m. The policy revealed psychoactive medications might be administered following federal and state regulations if the medication was necessary to treat a specifically diagnosed condition and was appropriately documented in the medical record. Additionally, behavioral interventions, unless contraindicated, would be used to meet the individual needs of the resident. The prescribing clinician would obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a psychotropic medication. The resident or resident's representative had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred. Prior to administration of a psychotropic medication, the prescribing clinician would obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record. A licensed nurse must verify that informed consent had been obtained from the resident or the resident's representative prior to administering psychotropic medication. A licensed nurse must also sign the consent form, declaring that the required material information has been provided. II. Resident #47 A. Resident status (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, other behavioral disturbances, Alzheimer's disease, palliative care and depression. According to the 10/18/24 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The assessment indicated the resident was administered antipsychotic and antidepressant medications. B. Record review A physician's order dated 8/21/24 at 8:24 p.m., revealed to administer Sertraline (Zoloft) HCL (an antidepressant medication) 25 milligrams (mg) orally once a day for anxiety and restlessness for seven days and then give two tablets by mouth once a day for anxiety and restlessness. A care plan for antidepressants (black box warning) for the use of Zoloft revealed the resident was at risk for suicidal thinking or abnormal behavior with the use of an antidepressant medication was initiated on 11/9/24. The interventions included to administer medication as physician ordered, observe for signs or symptoms of anxiety, constipation, diarrhea, dizziness, dry mouth, headaches, nausea, suicidal ideation, stomach upset, trouble sleeping, trouble urinating, weakness and fatigue and/or weight gain. The medication administration records (MAR) for November 2024, December 2024 and January 2025 were reviewed. The MARs revealed the antidepressant medication was administered to Resident #47 as the physician ordered. -However, review of Resident #47's electronic medical record (EMR) revealed there was no consent form, which included the risks versus the benefits of the medication, signed by the resident or the resident's representative prior to the administration of the medication. III. Staff interviews The NHA, the director of nursing (DON), regional director of clinical services (RDCS) #1 and RDCS #2 were interviewed together on 1/15/25 at 5:04 p.m. The NHA, the DON, RDCS #1 and RDCS #2 agreed there was no consent for Resident #47's use of the antidepressant Zoloft. The first administration date of this antidepressant medication was on 8/21/24 and continued to the present. The NHA, the DON, RDCS #1 and RDCS #2 agreed a consent should have been obtained before the start of the medication. The NHA, the DON, RDCS #1 and RDCS #2 agreed the reason to acquire a consent prior to the administration of an antidepressant medication was to help the resident or their legal representative understand the diagnosis, side effects and the effective outcomes for the use of the medication.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50690 Based on record review and interviews, the facility failed to ensure a prompt resolution was provided to residents involved in group grievances. Specifically, the facility failed to provide a prompt and effective resolution for resident council members who repeatedly voiced concerns over staff conduct. Findings include: I. Facility policy and procedure The Resident Council Meetings policy (no revision date), was provided by the nursing home administrator (NHA) on 1/16/25 at 6:23 p.m. It revealed in pertinent part, The facility shall act upon concerns and recommendations of the council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the council. The Resident and Family Grievances policy (no revision date), was provided by the NHA on 1/16/25 at 6:23 p.m. It revealed in pertinent part, A resident or family member may voice grievances with respect to care and treatment, the behavior of staff, and other concerns regarding their stay at the facility. Grievances may be voiced by a verbal or written complaint to a staff member or grievance official, or a verbal complaint during resident council meetings. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. The staff will take any immediate actions needed to prevent further potential violations of any resident rights. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance, which includes acknowledgment of the complaint/grievances and actively working toward a resolution. II. Resident group interview A group interview was conducted on 1/15/25 at 10:40 a.m. with seven residents (#46, #26, #23, #44, #59, #51 and #2) who were identified as alert and oriented through facility and assessment. All the residents said that the night shift staff was loud, slammed doors and were disrespectful. Resident #51 and Resident #59 said staff yelled at night. Resident #46, Resident #51 and Resident #59 said that staff slammed doors at night on purpose. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 and Resident #59 said staff were frequently on their phones at work. Resident #59 said many staff were rude. The residents said they did not feel the facility provided sufficient resolutions to their continued concerns about staff conduct. III. Resident council meeting notes Review of the 7/16/24 resident council meeting notes revealed residents had concerns that call lights were being ignored, facility certified nurse aides (CNA) were rude, gossiped about residents and that staff argued in the dining room where residents could hear. Review of the 8/13/24 resident council meeting notes revealed that residents felt nursing staff slammed doors on purpose, were disrespectful, turned around their name tags so residents could not report them and that staff lied to residents. The residents repeated concerns regarding staff arguments in the dining room. The 8/13/24 resident council meeting notes documented that problem employees had been replaced. -However, the 8/13/24 resident council meeting notes indicated the residents continued to have similar concerns about staff behavior from the 7/16/24 resident council meeting, despite staff being replaced. There was no resident council meeting held in September 2024 due to a corporate transition. There were no resident complaints documented about nursing staff at the October 2024 resident council meeting. Review of the 11/24/24 resident council meeting notes revealed the residents had concerns regarding CNAs and nurses entering residents' rooms while on their cellular phones and complaining about their jobs to residents. -There was no documentation in the 11/24/24 resident council meeting notes to indicate how the facility planned to address the concerns voiced at the 11/24/24 meeting. Review of the 12/30/24 resident council meeting notes revealed residents continued to have concerns of CNAs on their cellular phones while at work. There was documentation in the 12/30/24 resident council meeting notes which identified what staff needed to be educated on in regards to residents' call lights and cellular phone use at work, and that all staff would be educated. -However, the staff education was not scheduled until 1/22/25, over three weeks from the time the concerns were identified in the resident council meeting (see interview below). IV. Grievances (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no grievance forms provided by the facility for the resident concerns brought up in the 7/16/24, 8/13/24 or 11/24/24 resident council meetings. A group grievance was filed on 12/30/24 by the social services director (SSD). The grievance revealed ongoing complaints regarding staff conduct on the Summit unit of the facility. Resident council attendees complained of staff ignoring call lights and being rude when answering, ignoring phone calls at the nurse's station and being loud and disruptive at night, which made it hard for residents to sleep. The proposed resolution was to include all staff education on the residents' concerns, including the answering of phones at the nurses station, answering resident call lights and treating residents respectfully. Audits of call light and nurses station phones were going to be conducted. An interdisciplinary team (IDT) review of concerns would begin on 1/1/25 and an all-staff meeting was scheduled for 1/22/25. Resident #51 signed the proposed resolution on 12/31/24 and acknowledged that the concerns would take longer than a week to resolve. V. Staff interview The SSD was interviewed on 1/16/25 at 6:11 p.m. The SSD said all resident council complaints were discussed at the quality assurance and performance improvement (QAPI) committee meetings. She said that she filed group grievance forms when requested by the resident council. She said sometimes the resident council members did not want to file a formal grievance, so she said the residents' concerns might only be discussed in a QAPI meeting. She said the first few times that complaints about rude staff were voiced, education was completed with individual staff or larger in-services were held for multiple staff. The SSD said she investigated the specific staff that multiple residents repeatedly complained about, and those staff members had since been terminated. She said that resolution was satisfactory to the complainants. She said that the resident council had worked with her towards a resolution regarding continued complaints about rude staff, call light wait times and use of cell phones. She said the proposed resolution was the upcoming all-staff mandatory meeting, of which the residents approved. -However, residents voiced concerns related to staff conduct during the survey (see resident group interview above).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to inform one (#60) of three residents reviewed for beneficiary notices and appeal rights out of 30 sample residents of changes in their services covered by Medicare in a timely manner. Specifically, the facility failed to provide written notification of a Medicare Non-Coverage letter to the resident's representative that Medicare-covered services were ending for Resident #60 in a timely manner. Findings include: I. Facility policy and procedure The Medicare Advance Beneficiary and Medicare Non-coverage Notices policy, revised September 2022, was provided by the nursing home administrator (NHA) on 1/13/25 at 4:11 p.m. The policy revealed residents were informed in advance when changes would occur to their bills. If the resident's Medicare covered Part A stay or when all of Part B therapies were ending, a Notice of Medicare Non-Coverage (NOMNC) was issued to the resident at least two calendar days before benefits ended. II. Resident #60 A. Resident status Resident #60, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral infarction, metabolic encephalopathy, anxiety and major depression. According to the 12/27/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. The resident had inattention. The resident had difficulty focusing attention, including being easily distractible or having difficulty keeping track of what was said. This behavior was continuously present and did not fluctuate. The resident had disorganized thinking. The resident's thinking was disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). This behavior was continuously present and did not fluctuate. B. Record review The Skilled Nursing facility (SNF) Beneficiary Protection Notification Review revealed the resident's last covered Medicare Part A skilled service was on 10/31/24. The NOMNC was signed by the resident's legal representative on 10/31/24, which was the same day Resident #60's Medicare Part A benefits ended. The resident continued to reside in the facility. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility provided the NOMNC to Resident #60's legal representative on the same day the resident's Medicare Part A services ended, which was not sufficient notification that the current skilled nursing services would likely not be paid for by the Medicare provider and/or health plan and that the resident might have to pay for any services after this date (10/31/24). -Additionally, the untimely issuance of the NOMNC did not provide Resident #60's legal representative sufficient time to request for an immediate appeal of the discontinuation of skilled services, which ended on 10/31/24. III. Staff interviews The NHA, the director of nursing (DON), regional director of clinical services (RDCS) #1 and RDCS #2 were interviewed on 1/15/25 at 4:50 p.m. The NHA acknowledged Resident #60's last day of Medicare Part A skilled services was on 10/31/24 and that Resident #60's legal representative signed the NOMNC on 10/31/24. The NHA said the NOMNC should be provided to the resident or their representative at least two days in advance of the last day of skilled services coverage. The director of rehabilitation (DOR) was interviewed on 1/16/25 at 11:40 a.m. The DOR said, until September 2024, she was responsible for residents' beneficiary notifications. She said a resident or their legal representative should be notified 48 hours before the resident's last day of Medicare Part A skilled services was discontinued. The social services director (SSD) was interviewed on 1/16/25 at 2:13 p.m. The SSD said she was responsible for beneficiary notifications. She said residents or their representatives should be notified two days before the resident's Medicare Part A skilled services was discontinued.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to develop a comprehensive care plan for two (#46 and #9) of six residents out of 30 sample residents for services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to: -Ensure a comprehensive care plan was developed to address Resident #46's use of an anticoagulant medication; and, -Ensure a comprehensive care plan was developed to address Resident #9's dental needs. Findings include: I. Facility policy and procedure The Comprehensive Person-Centered Care Plans policy, revised March 2022, was provided by regional director of clinical services (RDCS) #2 on 1/15/25 at 5:00 p.m. The policy revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan was developed within seven days of the completion of the required minimum data set (MDS) assessment (admission, annual or significant change in status), and no more than 21 days after admission. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan: included measurable objectives and timeframes; described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. The plan would include any specialized services to be provided as a result of pre-admission screening and resident review program (PASARR) recommendations; and which professional services were responsible for each element of care; included the resident's stated goals upon admission and desired outcomes; built on the resident's strengths; and reflected currently recognized standards of practice for problem areas and conditions. Care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making. When possible, interventions addressed the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interdisciplinary team reviews and updates the care plan: when there had been a significant change in the resident's condition; when the desired outcome was not met; when the resident had been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. The resident had the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals were documented in the resident's clinical record in accordance with established policies. II. Resident #46 A. Resident status Resident #46, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included morbid obesity, peripheral vascular disease, cellulitis of the right lower limb, chronic obstructive pulmonary disease, lymphedema (chronic condition that causes swelling), chronic diastolic (congestive) heart failure and essential hypertension (high blood pressure). The 11/8/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident received anticoagulant medications. B. Resident interview Resident #46 was interviewed on 1/13/25 at 10:59 a.m. Resident #46 said he was administered an anticoagulant medication. He was able to name the medication and said he had no excessive bruising from the use of the medication. C. Record review A physician's order, dated 3/23/24 at 7:01 a.m., revealed to administer Eliquis 5 milligrams orally twice a day for anticoagulation. Resident #46's administration record (MAR) for November 2024, December 2024 and January 2025 were reviewed. The resident was administered the anticoagulant medication according to physician orders. -Resident #46's electronic medical record (EMR) was reviewed on 1/14/25 at approximately 3:00 p.m. The EMR did not contain a care plan for the use of an anticoagulant with interventions. D. Staff interviews (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional director of clinical services (RDCS) #2 was interviewed on 1/15/25 at 1:56 p.m. RDCS #2 said the MDS assessment dated [DATE] revealed the resident was administered an anticoagulant. RDCS #2 said the resident did not have a care plan for the use of an anticoagulant medication. She said a care plan should have been developed for the use of the anticoagulant within 24-hours after the first administration. RDCS #2 said the care plan for the use of an anticoagulant would alert staff to monitor for bruising, bleeding and any therapeutic effects for the use of the medication. RDCS #2 said all nursing staff management were responsible for the development of care plans. She said resident care plans were monitored and reviewed at least quarterly with MDS assessments, resident care conferences and any changes of cognition. The minimum data set coordinator (MDSC) was interviewed on 1/16/25 at 8:30 a.m. The MDSC said the MDS dated [DATE] revealed the resident was administered an anticoagulant medication. She said she developed care plans for medications. She said resident care plans were reviewed quarterly and at any changes in the resident's condition. 48112 III. Resident #9 A. Facility policy and procedure The Dental Services policy, revised 2024, was provided by RDCS #2 on 1/16/25 at 5:50 p.m. It read in pertinent part, The dental needs of each resident are identified through the physical assessment and MDS (minimum data set) assessment processes, and are addressed in each resident's plan of care. Oral/dental status shall be documented according to assessment findings. Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. Staff shall be mindful of resident dentures when providing care and alert to situations where dentures may be displaced, such as common with residents with dementia or those known to remove dentures at will and place them in areas other than the denture cup. Referrals to dietician, speech therapist, physician, or dental provider shall be made as appropriate. B. Resident status Resident #9, age 70, was admitted on [DATE]. According to the CPO, diagnoses included dementia, anxiety, psychotic disturbance, mood disturbance, periodontal disease (a bacterial infection that affected the gums and jawbone) and disorder of teeth. The 10/1/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 12 out of 15. The assessment revealed the resident did not have dental issues and did not have corrective lenses. C. Resident interview and observation (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 was interviewed on 1/13/25 at 2:46 p.m. Resident #9 said the dentist was here recently and the facility did not put her on the list to be seen by the dentist. She said she was upset the facility did not include her. The resident did not have glasses on and did not have dentures in her mouth. D. Record review The care plan was reviewed. -A review of Resident #9's comprehensive care plan, revised 1/15/25, did not reveal person-centered interventions to meet the resident's dental and vision needs. The 10/18/24 social service progress note revealed Resident #9 was seen by the dentist for a comprehensive exam and a full set of x-rays. The 10/29/24 admission social history assessment revealed the resident had a full set of dentures and did not have glasses. E. Staff interviews The social services director (SSD) was interviewed on 1/16/25 at 2:46 p.m. The SSD said she was responsible for ancillary services like dental services. The SSD said an assessment was completed when the resident was first admitted to the facility. The SSD said the assessments were not completed prior to her taking over as SSD. The SSD said she was the director for the last month. The SSD said Resident #9 needed dental services. The SSD said she was seen in October 2024 and was going to be seen again. The SSD said she left a message in the past week for the power of attorney to obtain consent. The SSD said there was not a care plan for dental services. The nursing home administrator (NHA), the director of nursing (DON) and RDCS #2 were interviewed together on 1/16/25 at 2:27 p.m. The DON said the SSD was responsible for dental and vision services. The DON said social services completed an assessment. RDCS #2 said all residents should be offered dental and vision services. The DON said dental and vision services should be care planned because once services were care planned, it was transferred to Kardex (an abbreviated care plan for staff). The DON said it was important to care plan dental services so the nursing staff knew on a daily basis if the resident wore glasses or had dentures. RDCS #2 said Resident #9 did not have a care plan for dental services.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to ensure one (#113) of three residents reviewed for assistance with activities of daily living (ADL) out of 30 sample residents received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure Resident #113 received assistance with showers in accordance with her physician orders. Findings include: I. Facility policy and procedure The Supporting Activities of Daily Living (ADL) policy, revised March 2018, was provided by the nursing home administrator (NHA) on 1/14/25 at 1:57 p.m. The policy revealed residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resisted care, staff would attempt to identify the underlying cause of the problem and not just assume the resident was refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident might be appropriate. II. Resident #113 A. Resident status Resident #113, age greater than 65, was admitted on [DATE] and discharged home on 9/16/24. According to the September 2024 computerized physician orders (CPO), diagnoses included vascular dementia, other disorders of the brain, major depression disorder, encephalopathy and mild neurocognitive disorder due to known physiological conditions with behavioral disturbances. The 6/28/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. The resident had inattention with difficulty in focusing attention, for example, being easily distractible or having difficulty keeping track of what was said. This behavior was continuously present and did not fluctuate. The resident had the ability to shower himself which included washing, rinsing, and drying himself (excluded washing of back and hair). The resident required setup or clean-up assistance. A staff member set up or cleaned up and the resident completed the activity. The staff member assisted only prior to or following the activity. B. Record review (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 3/26/24 at 2:56 p.m., revealed Resident #113's shower days were on Wednesdays and Saturday evenings. Staff were to write a progress note if the resident refused a shower. A care plan for Resident #113 refusing care at times was initiated on 9/18/24. The interventions were to educate staff on resident redirection and for staff to re-approach and provide care/assistance. The resident's electronic medical record (EMR) did not contain a care plan for ADLs that included showers. Review of Resident #113's EMR shower documentation for April 2024 revealed the resident received three showers and had two refusals out of eight opportunities for a shower. -There was no documentation in the EMR to indicate why the resident did not receive his other scheduled showers. -There was no documentation in the EMR to indicate why the resident refused his two showers or if the resident was re-approached at a later time. Review of Resident #113's EMR shower documentation for May 2024 revealed the resident received four showers and had no refusals out of nine opportunities for a shower. -There was no documentation in the EMR to indicate why the resident did not receive his other scheduled showers. Review of Resident #113's EMR shower documentation for August 2024 revealed the resident received four showers and had one refusal out of eight opportunities for a shower. -There was no documentation in the EMR to indicate why the resident did not receive his other scheduled showers. -There was no documentation in the EMR to indicate why the resident refused his one shower or if the resident was re-approached at a later time. III. Staff interviews The NHA, the director of nursing (DON), regional director of clinical services (RDCS) #1 and RDCS #2 were interviewed together on 1/15/25 at 5:11 p.m. The NHA, the DON, RDCS #1 and RDCS #2 reviewed Resident #113's shower documentation contained in the EMR for April 2024, May 2024 and August 2024 and agreed the resident had not received all of his showers. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the DON, RDCS #1 and RDCS #2 said residents should receive two or more baths/showers each week if they wanted them and if a resident refused a shower, the certified nurse aides (CNA) should ask the resident multiple times if they wanted a shower and then tell the nurse of the resident's refusal. The NHA, the DON, RDCS #1 and RDCS #2 said the nurse would then go ask the resident and offer a different time/date for the resident to take a shower. The NHA, the DON, RDCS #1 and RDCS #2 said if the resident still refused a shower, the nurse should write a progress note regarding the resident's refusal. The NHA, the DON, RDCS #1 and RDCS #2 said if a resident often refused a shower, it should be reflected in a care plan. CNA #3 was interviewed on 1/16/25 at 11:00 a.m. CNA #3 said she provided showers to residents. She said a resident should receive at least two showers per week. She said if a resident refused, she asked them several times during the shift if they wanted a shower. She said if a resident refused a shower, she would notify the nurse immediately. CNA #3 said when she came to work the next day, she would ask the resident again if they wanted a shower. She said she charted resident showers in the resident's EMR and on a shower sheet. She said she charted in the EMR during the shift or before the end of the shift. CNA #4 was interviewed on 1/16/25 at 11:06 a.m. CNA #4 said she provided showers to residents. She said a resident should receive two showers each week. She said if a resident refused a shower, she would ask the resident several times on that shift. She said she would tell the nurse immediately that the resident had refused showers. CNA #4 said during shift change, she would tell the oncoming CNAs that the resident refused. She said she documented showers in the resident's EMR and on the shower sheet. She said she charted after the shower was completed or before the end of the shift. RDCS #2 was interviewed on 1/16/25 at 11:34 a.m. RDCS #2 said there was no care plan for ADLs nor for bathing for Resident #113. She said a care plan should have been developed for ADLs and bathing.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure three (#32, #60, #50) of five residents reviewed for activities out of 30 sample residents received an ongoing program of activities designed to meet the needs and interests, and promote physical, medical and psychosocial well-being. Specifically, the facility failed to offer and provide a personalized activity program for Resident #32, Resident #60 and Resident #50. Findings include: I. Facility policy and procedure The Activities policy, revised 2024 (no specified month), was provided by regional director of clinical services (RDCS) #2 on 1/16/25 at 5:50 p.m. It read in pertinent part, Facility-sponsored group, individual, and independent activities were designed to meet the interests of each resident as well as support their physical, mental and psychosocial well-being. Activities encouraged both independence and interaction within the community. II. Resident #32 A. Resident status Resident #32, age 84, was admitted on [DATE]. According to the January 2025 computerized physician order (CPO), diagnoses included dementia, insomnia, psychotic disturbance, mood disturbance and anxiety. The 12/13/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview (BIMS) score of zero out of 15. The assessment revealed the resident wandered four to six days during the seven-day assessment look-back period. The assessment revealed it was very important to the resident to listen to music she liked, to do her favorite activities, to go outside for fresh air when the weather was good and to participate in religious services and practices. The assessment revealed the resident did not refuse care. B. Resident's representative interview (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's representative was interviewed on 1/13/25 at 10:50 a.m. The representative said she visited Resident #32 in December 2024. She said she was concerned the resident did not participate in activities. She said the resident wandered the secured unit frequently. She said the staff redirected the resident to take a nap during the daytime. She said she was concerned Resident #32 slept during the day because she did not participate in the facility's activities. C. Observations During a continuous observation on 1/14/25, beginning at 11:16 a.m. and ending at 2:26 p.m. the following was observed: From 11:16 a.m. to 11:39 a.m. Resident #32 wandered the secured unit hallways. At 11:39 a.m. an unidentified therapy aide walked the hallways with Resident #32. At 11:45 a.m. Resident #32 sat in a chair at a dining table. At 12:49 p.m. Resident #32 left her chair at the dining table and began wandering the secured unit hallways. No staff attempted to redirect the resident or engage her with any activities. At 1:23 p.m. certified nurse aide (CNA) #3 escorted the resident to her room, but did not engage her with any activities. At 1:37 p.m. activities assistant (AA) #1 and AA #2 started an activity called mellow music. Resident #32 was not encouraged by AA #1 or AA #2 to participate in the activity. During a continuous observation on 1/15/25, beginning at 8:52 a.m. and ending at 11:55 a.m. the following was observed: At 9:00 a.m. Resident #32 sat in a chair at a dining table in the dining area. At 9:11 a.m. Resident #32 left her chair and wandered the secured unit to her room. Staff did not offer to engage the resident in any activities. At 10:33 a.m. AA #1 and AA #2 started an exercise with two medium size inflatable balls. AA #1 and AA #2 engaged residents by tossing the ball back and forth. -However, AA #1 and AA #2 did not engage Resident #32 in the activity. At 11:23 a.m. Resident #32 walked into the dining area with licensed practical nurse (LPN) #3. LPN#3 told Resident #32 to follow her to a chair in front of a dining table so she could take her medications and get ready for lunch. Resident #32 remained in her chair until lunch was served. D. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities care plan, revised 3/28/24, revealed Resident #32 was independent and made her needs known to staff in her primary language of Vietnamese. The resident was Vietnamese speaking only. The resident liked to walk around the secured neighborhood, socialize with peers even if she could not understand them, listen to music, attend music therapy, social groups and gardens. The resident needed therapeutic one-on-visits to help with feelings of isolation, loneliness, and boredom related to unwillingness to participate in activities and to assist with cultural programming and opportunities. The goal was to participate in independent leisure activities, as well as one-on-one visits with staff. The resident would participate in group activities one to three times per week. Interventions include encouraging the resident to stay in the group for the duration of the time, providing clutter free spaces to walk safely throughout the secured unit, encouraging the resident to participate and socialize with peers, inviting the resident to actively participate in all activities she may enjoy and providing the resident with an activity calendar. -A review of Resident #32's electronic medical record (EMR) revealed no documentation that the resident had participated in leisure activities, one-on-one visits or group activities. -A request for Resident #32's paper activities participation record was made to the nursing home administrator (NHA) on 1/16/25 at 4:44 p.m. The NHA was unable to provide documentation of the resident's activity participation. III. Resident #60 A. Resident status Resident #60, age 70, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included dementia, mood disturbance, psychotic disturbance, anxiety and major depressive disorder. The 12/27/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of one out of 15. The assessment revealed the resident did not reject care. The resident wandered one to three days during the seven-day assessment look-back period. The 9/26/24 MDS assessment documented the resident was rarely/never understood and family/significant other was not available, therefore the resident's preferences for customary routines and activities was not assessed. B. Observations During a continuous observation on 1/15/25, beginning at 8:52 a.m. and ending at 11:55 a.m. the following was observed: At 9:00 a.m. Resident #60 was sitting in a chair in the dining room. At 9:01 a.m. Resident #60 tried to stand. LPN #3 told LPN #4 to keep an eye on Resident #60 because she tried to stand. LPN #4 took the resident to her room but did not engage the resident in any activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:02 a.m. Resident #60 came out of her room and an unidentified dietary aide assisted the resident to sit in a chair in the dining area. At 9:12 a.m. Resident #60 got up from the chair and began to wander through the secured unit. Staff did not attempt to redirect the resident or engage the resident in any activities. At 10:18 a.m. CNA #4 redirected Resident #60 to sit down but did not provide the resident with any activities. At 10:33 a.m. AA #1 and AA #2 started an exercise with two medium size inflatable balls. AA #1 and AA #2 engaged residents by tossing the ball back and forth. -However, AA #1 and AA #2 did not engage Resident #60 in the activity and the resident continued to sit in the chair at the dining table. At 10:43 a.m. AA #1 said the exercise was over and she would turn on a movie. The television was on the south side of the room facing the north side. Resident #60 was on the south side of the room facing the north side. -No staff attempted to encourage Resident #60 to move to watch the movie. C. Record review The activities care plan, revised 11/20/24, revealed Resident #60 needed activities consistent with her abilities and interests. The resident enjoyed aroma therapy, music, sensory activities, socializing, and dancing. Interventions included assisting the resident to and from activity locations as needed, assisting with in-room activities as needed and room visits for socialization. -A review of Resident #60's EMR revealed no documentation that the resident had participated in leisure activities, one-on-one visits or group activities. -A request for Resident #60's paper activities participation record was made to the NHA on 1/16/25 at 4:44 p.m. The NHA was unable to provide documentation of the resident's activity participation. IV. Resident #50 A. Resident status Resident #50, age 81, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included Alzheimer's disease, insomnia, unsteadiness on feet, a history of falling and cognitive communication deficit. The 12/27/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of two out of 15. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment revealed it was very important to the resident to listen to music he liked and somewhat important to have books, newspapers, and magazines to read, somewhat important to be around animals such as pets, somewhat important to do things with groups of people and somewhat important to do his favorite activities. B. Record review The activities care plan, revised 4/8/24, revealed Resident #50 was very friendly and liked to do arts and crafts, mostly making paper birds. He needed help to join group activities every day. The care plan goal was to participate in one to three activities of interest, including music groups, community meetings, trivia and game groups. Interventions included staff were to encourage and assist the resident in meeting and socializing with other residents and participating in all activities he may be interested in or would enjoy. -A review of Resident #50's EMR revealed no documentation that the resident had participated in leisure activities, one-on-one visits or group activities. -A request for Resident #50's paper activities participation record was made to the NHA on 1/16/25 at 4:44 p. m. The NHA was unable to provide documentation of the resident's activity participation. V. Staff interviews LPN #2 was interviewed on 1/16/25 at 12:24 p.m. LPN #2 said the activities director (AD) was responsible for carrying out the activities schedule. He said residents liked exercise activities and reading. He said he was not sure what activities Resident #50 liked to participate in. He said Resident #60 liked to participate in whatever activities were going on. He said Resident #32 liked to participate in music and karaoke activities and she liked to watch others participate in activities. LPN #2 said activities were important in the secured unit because the residents needed to be consistently engaged to distract the residents from negative thoughts. The AD was interviewed on 1/16/25 at 2:53 p.m. The AD said she was the social services director (SSD) and was filling in as the interim AD until a new AD was hired. She said the activities department was not staffed. She said the activities department was approved to have five activities staff members, including the AD, one assistant activities director, two full time activities assistants and one part time activities assistant. She said AA #1 was a CNA who transitioned to AA #1 in the past month. She said AA #2 started working at the facility on 1/13/25. The AD said if a resident participated in an activity, it was documented on a paper charting system. She said activities were determined based on the resident's preferences and their cognitive abilities. The AD said the current activities were based on the new hires abilities to conduct activities until they were trained. The NHA was interviewed on 1/16/25 at 6:46 p.m. The NHA said he was unable to provide accurate documentation on what activities were provided for Resident #32, Resident #60 and Resident #50. The NHA said he could not confirm if person-centered activities were provided for the residents.

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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. 48112 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 two of five certified nurse aides (CNA) reviewed. Specifically, the facility did not complete a performance review for CNA #3 and CNA #4. Findings include: I. Record review CNA #3 was hired on 2/1/23. A request for a performance review was made on 1/14/25. -The facility was unable to provide documentation indicating a performance review for CNA #3 was completed in the past 12 months. CNA #4 was hired on 12/22/23. A request for a performance review was made on 1/14/25. -The facility was unable to provide documentation indicating a performance review for CNA #4 was completed in the past 12 months. II. Staff interviews Regional director of clinical services (RDCS) #2 was interviewed on 1/16/25 at 10:52 a.m. RDCS #2 said an annual performance review and in-service education were not completed for CNA #2 and CNA #4. RDCS #2 said she was not sure why the training had not been completed. The nursing home administrator (NHA) was interviewed on 1/16/25 at 2:16 p.m. The NHA said performance reviews should be completed annually based on the CNA's start date. The NHA said a performance review was not completed for CNA #3 and CNA #4. The NHA said she was not sure why the training had been completed.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observation,record review and interviews, the facility failed to assist residents in obtaining routine or emergency dental services, as needed for one (#14) of two residents reviewed for dental services out of 30 sample residents. Specifically, the facility failed to ensure dental services were offered to Resident #14. Findings include: I. Facility policy and procedure The Dental Services policy, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 4:44 p.m. It read in pertinent part, It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. The dental needs of each resident are identified through the physical assessment and MDS (minimum data set) assessment processes, and are addressed in each resident's plan of care. Oral/dental status shall be documented according to assessment findings. Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. Referrals to dietician, speech therapist, physician, or dental provider shall be made as appropriate. For residents or resident representatives who do not wish to be referred for dental services: The physician shall be notified, the dietician shall be consulted to assess for any necessary change in diet and the resident's plan of care will be revised to reflect preferences. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. II. Resident #14 A. Resident status Resident #14, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included spastic quadriplegic cerebral palsy (a condition that includes severe developmental delay, increased muscle tone and involuntary movements). (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/4/24 minimum data set (MDS) assessment revealed the resident had short term and long term memory problems and had severely impaired cognition and decision making per staff assessment. He was dependent on staff for all care, including oral care. The MDS assessment did not indicate if the resident had any dental problems. B. Observation On 1/13/25 at 11:51 a.m., Resident #14 had a thick layer of white substance along his upper teeth and gum line. C. Record review The ancillary services care plan, revised 10/3/24, revealed a focus for ancillary services, which included dental needs. The goal was for visits to be reviewed quarterly. The intervention was for social services to monitor when Resident #14 was seen by ancillary providers in order to maintain compliance with regulations regarding frequency of ancillary visits ands. S social services was to notify ancillary providers if the resident needed to be seen prior to their visit. A review of the January 2025 CPO revealed the resident had a physician's order to receive dental consults and follow up as needed, ordered 7/26/23. Review of Residents #14's consent forms, revealed a signed ancillary consent form on 10/4/23 for audiology services only. -Review of Resident #14's electronic medical record (EMR) revealed the resident did not have a signed consent form for dental services. A social services progress note, dated 4/4/24, revealed Resident #14 agreed to ancillary services, including podiatry and dentistry. A dental referral to an outside facility for completing dental work under anesthesia had been requested and the facility was waiting on the resident's representative's approval. -However, there was no further documentation in Resident #14's electronic medical record (EMR) to indicate dental services or the referral had been discussed since 4/4/24. III. Staff interviews The social services director (SSD) was interviewed on 1/14/25 at 2:45 p.m. The SSD said she started in this position a month ago. The SSD said there was a facility dentist that came at least every other week and had a list of residents with specific needs. The SSD said the dentist did evaluate everyone. She said processes had changed since she took this position. She said she had completed an audit to see which residents needed ancillary services. She said all ancillary service providers, including dental, vision and audiology would now see every resident at the facility to start the process. She said needed consents were signed and the dentist came last Friday 1/10/25. -However there was no documentation that Resident #14 or his representative had been contacted regarding dental services. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said she was surprised that there was no documentation in Resident #14's EMR about dental services. She said this resident was listed as needing ancillary services, so she was not sure why he had not been seen by a dentist in so long. The SSD said she put Resident #14 on the dentist's list for the coming week and that the dentist should know why the resident had not been seen recently. Licensed practical nurse (LPN) #5 was interviewed on 1/16/25 4:15 p.m. LPN #5 said she was not sure when the dentist came to the facility, but she knew it was often. She said if a resident had a new concern and the dentist was not in the facility, she wrote a progress note in the resident's EMR and called the resident's primary provider. She said the facility's providers were at the facility on Monday through Friday and also looked at the resident's teeth. She said she regularly cared for Resident #14 and there had been no concerns related to his teeth. She said his teeth were cleaned daily and as needed with a foam swab, oral moisturizer and water. She said for Resident #14, who could not swallow, oral swabs were preferred over toothbrushes. She said most of the certified nurse aides (CNA) and occupational therapists provided the resident with regular oral care because he was fully dependent on care. Regional director of clinical services (RDCS) #1 and the director of nursing (DON) were interviewed together on 1/16/25 at 4:43 p.m. RDCS #1 said that the standard was for residents to get oral care twice a day. RDCS #1 and the DON said there were guardianship concerns with Resident #14, so it was possible that someone did not want him to receive excessive treatments, but they were not certain. RDCS #1 said the resident's white coating along his gum line was calcium deposits, which happened when the teeth did not get regular scaling at the dentist's office. She said she did not think the resident would tolerate scaling. RDCS #1 said sometimes with residents who received enteral feedings (tube feedings) like Resident #14, staff did not remember that they needed dental care like the other residents. She said Resident #14 should have at least received dental screenings and thought the resident got lost in the shuffle after the facility changed ownership. She said there was a new system in place now to track such ancillary visits and that staff needed more education and teaching related to this.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations and interviews the facility failed to store, prepare, distribute and serve food in a sanitary manner in the kitchen. Specifically, the facility failed to: -Ensure raw animal food was separated from ready to eat food; -Ensure expired food was discarded; and, -Ensure food was labeled and dated appropriately. Findings include: I. Failed to prevent food contamination The Colorado Retail Food Establishment Rules and Regulations, ([DATE]), retrieved on [DATE] read in pertinent part, Food shall be protected from cross contamination by separating raw animal food during storage, preparation, holding, and display from raw ready-to-eat food including fruits and vegetables. (Chapter ,d+[DATE]) A. Observations On [DATE] at 2:14 p.m, the main kitchen walk-in refrigerator had a cardboard box with five plastic bags of raw chicken thighs on the middle shelf. The chicken thighs were stored next to individual milk cartons. The raw chicken thighs were above a cardboard box of oranges, above a cardboard box of onions and above a cardboard box of apples. B. Staff interviews and observations The dietary manager (DM) was interviewed during a walk through of the kitchen walk-in refrigerator on [DATE] at 3:27 p.m. The DM said the box of chicken thighs should be separated from the ready to eat food. The chicken thighs remained in the same location (see observations above). The DM moved the cardboard box of chicken thighs to a metal rolling cart in the middle of the walk-in refrigerator. The nursing home administrator (NHA) was interviewed on [DATE] at 6:18 p.m. The NHA said the raw chicken thighs should have been separated from the fruits and vegetables to prevent cross-contamination. He said the raw chicken thighs should have been placed on a metal tray in case the plastic bags had a leak to prevent chicken thigh juices from dripping onto other food stored in the walk-in refrigerator. II. Failed to ensure expired food was discarded A. Professional reference (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Colorado Retail Food Establishment Rules and Regulations, ([DATE]), retrieved on [DATE] read in pertinent part, The day or date marked by the food establishment may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on food safety. (Chapter ,d+[DATE]) B. Observations On [DATE] at 2:14 p.m., in the main kitchen walk-in refrigerator there was a square metal food storage container on the middle shelf on the left side of the refrigerator. The container was labeled with beef gravy, dated [DATE] and labeled with a use by date of [DATE]. C. Staff interviews The DM was interviewed on [DATE] at 3:27 p.m. The DM said the facility labeling system was to include the date the food was prepared and the use by date. She said the gravy that was labeled with a date of [DATE] and use by date of [DATE] indicated the gravy was prepared on [DATE] and it needed to be discarded on [DATE]. The NHA was interviewed on [DATE] at 6:18 p.m. He said he did not know how the kitchen labeling system worked. He said if the gravy was labeled to discard on [DATE], the gravy should have been discarded on [DATE]. III. Failed to ensure food was labeled and dated A. Professional reference The Colorado Retail Food Establishment Rules and Regulations, ([DATE]), retrieved on [DATE] read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter ,d+[DATE]) B. Observation On [DATE] at 2:14 p.m., in the main kitchen walk-in refrigerator, there was a square metal food storage container that was on the middle shelf on the left side of the refrigerator. The container had 13 individual plastic containers with a pureed food in them. The containers were not labeled with a date and without a common name of the food. C. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM was interviewed on [DATE] at 3:27 p.m. The DM said food items removed from the original packaging should be labeled with the name of the food, when it was opened and a use by date. She said she did not know why the food items were not labeled. The NHA was interviewed on [DATE] at 6:18 p.m. The NHA said food items removed from the original packaging should be labeled with the name of the food, when it was opened and a use by date.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to ensure that the medical record was complete and accurate in keeping with accepted standards of practice for one (#63) of four residents reviewed for medical record accuracy out of 30 sample residents. Specifically, the facility failed to document Resident #63's toileting in an accurate and easy to understand manner. Findings include: I. Facility policy and procedure The Charting and Documentation policy, revised December 2022, was provided by regional director of clinical sciences (RDCS) #2 on 1/16/25 at 3:02 p.m. The policy revealed the services provided to the resident progress toward the care plan goals. Any notable changes in the resident's medical, physical, functional, or psychosocial condition observed by staff should be documented in the resident's medical record. The medical record was a format that facilitated communication between the interdisciplinary team. Documentation in the medical record might be entered electronically, manually on paper or a combination of both. The following information were examples of documentation that may be included in the resident medical record: objective observations, medications administered, treatments or services performed and changes in the resident's condition, if indicated. Entries included in the resident's clinical record should be made by licensed personnel such as registered nurses (RN), license practical nurses (LPN) and physicians/practitioners. To avoid confusion and promote consistency in charting and documentation of the resident's clinical record, only commonly used and understood abbreviations should be used. Documentation of procedures and treatments should include care-specific details, including items such as the date and time the procedure/treatment was provided, the name and title of the individual(s) who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment, if applicable, whether the resident refused the procedure/treatment, notification of family, physician or other staff, if indicated and the signature and title of the individual documenting. I. Resident #63 A. Resident status Resident #63, age greater than age 65, was admitted on [DATE] and passed away at the facility on 12/8/24. According to the December 2024 computerized physician orders (CPO), diagnoses included dementia, chronic obstructive pulmonary disease, delusional disorder, cerebral infarct without residual deficits, anxiety, unsteadiness on feet and heart failure. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. The resident required a staff member to provide all of the effort for toileting. The resident did not provide any effort to complete the toileting activity or the resident required the assistance of two or more staff members for the resident to complete the activity. B. Record review Resident #63 had a physician's order to toilet the resident every two hours for prompted toileting, ordered on 4/22/24 at 4:00 p.m., and discontinued on 10/31/24 at 4:18 p.m. The order was documented on the resident's treatment administration record (TAR). -The physician's order did not specify how staff were to document the resident had promoted toileting. Resident #63's Kardex (a patient care summary that provided nurses with a quick reference to a resident's key care information) received on 1/16/25 at 10:36 a.m., revealed staff was to toilet the resident as needed. A bedside commode was brought into the resident's room for toileting needs every two hours. Resident #63's TARs for August 2024, September 2024 and October 2024 were reviewed related to the physician's order for prompted toileting every two hours. The staff used the following notations (symbols) every two hours: N (no), Y (yes), NA (not applicable), + (plus), - (minus), 0 (zero), W (unknown delineation), WB (unknown delineation), D (unknown delineation), B (unknown delineation), R (unknown delineation), and P (unknown delineation). A care plan for Resident #63 being at risk for falls due to unawareness of safety needs, mobility deficit, and forgetfulness was revised on 12/9/24. The interventions included to anticipate the resident's needs. Staff were to supervise the resident at all times during toileting, and the resident was not to be left unattended in the bathroom. The resident would be provided a bedside commode after a physical therapy assessment and the resident was deemed able to use the commode. A care plan for Resident #63, who had a history of attempting to use the toilet outside of her toileting schedule was revised on 11/27/24. The interventions included the resident wore a tabbed brief for incontinence, staff were to follow the facility bowel protocol for bowel management and record bowel pattern movements each day. II. Staff interview The NHA, the director of nursing (DON), regional director of clinical services (RDCS) #1 and RDCS #2 were interviewed together on 1/15/25 at 5:30 p.m. Resident #63's TARs for August 2024, September 2024 and October 2024 were reviewed. The NHA, the DON, RDCS #1 and RDCS #2 agreed on the inconsistent methods (symbols) of staff documentation for the resident's toiling program every two hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said that the plus (+) symbol meant a bowel movement, the minus (-) symbol meant no bowel movement. However, the DON said she did not know the meaning of the other symbols the staff were documenting. The DON said Resident #63's physician's order did not tell the staff how to document the resident's toileting. The DON said the nurse that took the physician's order should have included in the physician's order how the staff should document the resident's toileting. The DON said, looking at the documentation for Resident #63's toileting program, she could not determine if the resident received toileting according to the physician's order due to the inconsistent methods (symbols) of documentation used by the staff.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50690 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the laundry room was free from multiple environmental concerns. Findings include: I. Observations An environmental tour of the facility was conducted on 1/16/25 at 9:15 a.m. The following observations were made: There was an area of wall damage at the bottom of the basement staircase on the left hand side. There was approximately two vertical feet of uncovered wall with exposed metal and a screw. Both were sharp to the touch. In the laundry room the following were observed: -There was damage to the sheetrock on the ceiling above and in front of the washing machine. It had fallen off the concrete above. The area was approximately four feet around. -There was chipped paint along the upper wall next to the washing machine. -There was a hole in the wall along the floor next to the laundry folding table. -The plastic floor trim near the laundry folding table was peeling. II. Staff interview The maintenance supervisor (MS) was interviewed on 1/16/25 at 10:30 a.m. The MS completed an environmental tour of the facility. He said there was damage to the sheetrock on the ceiling in front of the washing machine, chipped paint along the upper wall next to the washing machine, a hole in the wall along the floor next to the laundry folding table and the trim near the laundry folding table was peeling. The MS said the observed maintenance concerns had been present since he started in the position a few years ago. He said there were no work orders for the concerns, but the holes and wall damage along the stairwell were going to be repaired after the new washing machine was delivered. He said the extra space created at the bottom of the basement stairs and doorway was needed to accommodate the size of the machine. He said there was a signed proposal for the repairs to be done but he was not sure of the date that would occur. He said the repairs included tearing out the bottom three stairs and repairing the hole and entryway.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48112 Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for staff based on the facility assessment and resident population for four of five certified nurse aides (CNA) reviewed. Specifically, the facility failed to: -Ensure CNA #5 and CNA #6 received training in abuse, dementia management, behavioral health management, infection control, communication, quality assurance and quality improvement (QAPI), compliance and ethics, and resident rights; and, -Ensure CNA #3 and CNA #4 received at least 12 hours of annual in-service training. Findings include: I. Record review A request for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training was made on 1/14/25 for CNA #5 and CNA #6. CNA #5 was hired on 1/13/25. CNA #6 was hired on 1/12/25. -The facility was unable to provide documentation indicating CNA #5 and CNA #6 completed training for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights prior to providing direct care to residents independently. Record review of the daily schedule revealed CNA #5 worked in the secure unit on 1/13/25 from 2:00 p.m. to 10:00 p.m. Record review of the daily schedule reviewed CNA #6 worked in the secure unit on 1/12/25. A request for 12 hours of in-service training was made on 1/14/25 for CNA #3 and CNA #4. CNA #3 was hired on 2/1/23. -The facility was unable to provide documentation 12 hours of in-service training was completed in the past 12 months. CNA #4 was hired on 12/22/23. -The facility was unable to provide documentation 12 hours of in-service training was completed in the past 12 months. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Staff interviews Regional director of clinical services (RDCS) #2 was interviewed on 1/16/25 at 10:52 a.m. She said CNA #5 and CNA #6 were hired through a staffing agency. She said the required training was requested by the staffing agency. The RDCS said the staffing agency did not require CNAs to complete any training abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 1/16/25 at 2:16 p.m. The DON said the facility held monthly staff meetings that included the CNAs. The DON said she could not confirm CNA #3 and CNA #4 had 12 hours of in-service training.