STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065244	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Springs Healthcare	2305 Blake Ave Glenwood Springs, CO 81601

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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 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. 40467 Based on record review and resident interviews, the facility failed to promptly address and attempt to resolve resident group complaints and grievances concerning issues of resident care and life in the facility that were important to the residents. Specifically, the facility failed to ensure residents felt their concerns with call light timeliness resulting in long waits for staff assistance were addressed and resolved. Findings include: I. Facility policy and procedure The Resident Council policy, undated, was provided by the nursing home administrator (NHA) on 10/17/24 at 6:04 p.m. The policy read in pertinent part, The purpose of the resident council is to provide a form for: residents families and resident representatives to input in the operation of the facility; discussion of concerns and suggestions for improvement; consensus building and communication between residents and facility staff; and, disseminating information and gathering feedback from interested residents. A resident council response form will be utilized to track issues and their resolutions. The facility department related to any issues will be responsible for addressing the items of concern. The quality assurance and performance improvement committee (QAPI) will review information and feedback from the resident council as part of their quality review. Issues documented on council response forms may be referred to the committee, if applicable. II. Resident group interview A group interview was conducted on 10/16/24 at 10:32 a.m. with five residents (#2, #8, #15, #16 and #21) the facility assessed and deemed as alert, oriented and interviewable. According to the group, the residents did not feel the facility addressed their concerns of long call light times. Resident #8 said she recently had to wait over an hour and a half before her call light was answered. She said she had to use the restroom and lay down in bed. She said she had horrible back pain but laying down usually helped. She said because she had to wait so long for assistance, it took a day for her to recover from the pain. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 said some of the nurses did not help answer call lights and relied on the certified nurse aides (CNA) to answer the call lights. She said last month (September 2024) she had to wait over an hour for her call light to be answered. Resident #16 said last Thursday (10/10/24) he had to wait from 4:15 a.m. to 6:00 a.m. for his call light to be answered. The group said the longest waits were usually during the night. III. Resident council minutes The July 2024 resident council minutes documented call lights were addressed as a concern. According to the minutes, call lights were not always timely. The action item on the minutes indicated the resident council was told some of the residents required two staff for transferring, potentially taking the CNAs a little longer to get to the call light. -The July 2024 council minutes did not identify what the facility was going to do to address the concern of inconsistent call light times. The July 2024 resident council grievance form for call light timeliness was requested but was not provided by the facility. The August 2024 and September 2024 resident council minutes did not document the July 2024 concern of inconsistent call light was reviewed with the resident council to determine whether the concern was resolved or not. IV. Call light record The electronic call light log between 10/2/24 and 10/15/24 was provided by the operations manager (OM) on 10/16/24 at 6:21 p.m. A five day sample of call light response time, from 10/1/24 to 10/14/24, identified the following: On Wednesday 10/2/24, a total of 200 total call lights were turned on for resident assistance. -40 of the call lights were activated for over 15 minutes before they were answered; -Six of the call lights were answered between 20 and 29 minutes; -14 of the call lights were answered between 30 and 39 minutes; -Two of the call lights were answered between 40 and 49 minutes; -Two of the call lights were answered between 50 and 59 minutes; and, -Three call lights were activated for over an hour before the resident's call light was answered. On Thursday 10/3/24, a total of 150 total call lights were turned on for resident assistance. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-32 of the call lights were activated for over 15 minutes before they were answered; -Seven of the call lights were answered between 20 and 29 minutes; -Three of the call lights were answered between 30 and 39 minutes; -Seven of the call lights were answered between 40 and 49 minutes; and, -Two of the call lights were answered between 50 and 59 minutes. On Sunday 10/6/24, a total of 162 total call lights were turned on for resident assistance. -14 of the call lights were activated for over 15 minutes before they were answered; -Seven of the call lights were answered between 20 and 29 minutes; -One call light was answered between 30 and 39 minutes; and, -One call light was activated for over an hour (one hour and 33 minutes) before the resident's call light was answered. On Monday 10/7/24, a total of 162 total call lights were turned on for resident assistance. -32 of the call lights were activated for over 15 minutes before they were answered; -12 of the call lights were answered between 20 and 29 minutes; -Two of the call lights were answered between 30 and 39 minutes; and, On Monday 10/14/24, (the first day of the survey period) a total of 200 total call lights were turned on for resident assistance. -11 of the call lights were activated for over 15 minutes before they were answered; -Three of the call lights were answered between 20 and 29 minutes; -One call light was answered between 30 and 39 minutes; -One call light was answered between 40 and 49 minutes; and, -Two call lights were activated for over an hour before the resident's call light was answered. V. Staff interviews (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activity director (AD) was interviewed on 10/17/24 at 5:00 p.m. The AD said during resident council, the prior resident council concerns were reviewed each month to determine if the concern was resolved or still an ongoing concern. She said the status of the concern would be documented in the minutes. The AD said if the resident council had a new concern or an unresolved concern that was ongoing, she would add the concern to a grievance form. She said the grievance would be submitted to the appropriate department to address the council. The completed grievances would be turned in to the social service director (SSD). The AD said she was not in her position in July 2024 when the resident council brought up the concern of inconsistent call light timeliness. The AD said she would not have known of the call light concern in July 2024 to review in the August 2024 resident council because she was new to her position and was not aware of the July 2024 call light concern. She said she did not review the July 2024 resident council concerns prior to the August 2024 council meeting. The social service director (SSD) said was responsible for filing all grievances from residents and resident council. The SSD said she had not received a call light grievance from the July 2024 resident council meeting. The operations manager (OM) and the NHA was interviewed on 10/17/24 6:32 p.m. The OM said resident feedback was how the facility determined if resident council concerns were appropriately addressed and resolved. He said the concern would be brought up the following to determine if the concern was resolved. He said if the resident council felt the concern remained unresolved, a new grievance would be submitted and addressed for resolution until the resident said they were satisfied. The NHA said call light timeliness was reviewed in QAPI on 10/17/24 (during the survey). The NHA said interdisciplinary team (IDT) reviewed the electronic call light logs and determined more the facility needed to do call light spot audits.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50314 Based on observation and interviews, the facility failed to ensure one (#12) of one of 26 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to ensure Resident #12's blood pressure was measured appropriately in accordance with medical standards of practice. Findings include: I. Professional reference How to measure your blood pressure at home fact sheet, dated 2020, was retrieved on 10/21/24 from the American Heart Association medical archives at https://www.heart.org/-/media/Files/Health-Topics/High-Blood-Pressure/measuringbpathome.pdf It documented that the blood pressure cuff should be positioned on the bare arm above the elbow in the middle of the arm. II. Facility policy and procedure The Blood Pressure, Measuring policy, revised September 2010, was provided by corporate consultant (CC) #1 on 10/17/24 at 3:41 p.m. It documented in pertinent part, Expose the resident's arm by rolling the sleeve up about five inches above the elbow. II. Observation On 10/17/24 at 8:42 a.m. registered nurse (RN) #2 was taking Resident #12's blood pressure. Resident #12 was wearing a pink fleece sweater and offered to roll up her sleeve for the blood pressure measurement. RN #2 declined Resident #12's offer and said that she could take a blood pressure over the clothing items because she had good ears. RN #2 then placed the blood pressure cuff on Resident #12's upper arm over the pink fleece sweater to obtain the blood pressure measurement. RN #2 then documented the blood pressure measurement in the electronic medical record (EMR). III. Staff interviews RN #2 was interviewed on 10/17/24 at 8:51 a.m. RN #2 said that it was normal and acceptable to obtain a resident's blood pressure over clothing. RN #2 said obtaining a blood pressure in this manner would not affect the accuracy of the blood pressure measurement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 10/17/24 at 4:08 p.m. The DON said that a blood pressure device could be placed over resident clothing to obtain an accurate blood pressure if the clothing was thin. The DON said she did not know if Resident #12's pink fleece sweater would be thick enough to affect the blood pressure measurement. The DON reviewed the American Medical Association and American Heart Association recommendations for obtaining an accurate blood pressure reading (see professional reference above). The DON said she did not know the American Heart Association recommendations included placing the blood pressure measurement device on the bare arm for accurate measurement.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure one (#15) of three residents reviewed for activities out of 26 sample residents received individualized activities in accordance with standards of care. Specifically, the facility failed to offer Resident #15 activities in Spanish, which was his preferred language. Findings include: I. Resident #15 A. Resident status Resident #15, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included kidney failure, bipolar disorder and type 2 diabetes. According to the 7/17/24 minimum data set (MDS) assessment, Resident #15 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was independent in completing all activities of daily living. According to the 1/15/24 MDS assessment, it was very important for Resident #15 to have books, magazines and newspapers to read., listen to music he liked., do his favorite activities, go outside and get fresh air when the weather was good and participate in religious services. B. Resident interview and observation Resident #15 was interviewed, in Spanish, on 10/14/24 at 3:18 p.m. Resident #15 said he was raised speaking Spanish only and his preferred language was Spanish. Resident #15 said he understood some phrases and words in English, but he was not fluent in English. Resident #15 said he had not been provided with activities in the Spanish language. Resident #15 said he was given word finding books but they were all in English. Resident #15 presented four different word finding books from his bedside table that were written in the English language. Resident #15 said he enjoyed speaking Spanish with the housekeeping staff when he could but they were often too busy to talk to him. Resident #15 said he had no memory of any activity being provided to him in the Spanish language. Resident #15 said he often felt forgotten because he was the only resident who spoke Spanish primarily at the facility. C. Additional observation (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The posted facility activity board for the month of October was observed on 10/16/24 at 11:04 a.m. The activity board did not include any activities in the Spanish language for the month of October 2024. D. Record review Resident #15's activity plan of care, initiated on 7/5/21 and revised 10/24/23 revealed a goal for Resident #15 to participate in activities three to five times per week. It documented Resident #15's in-room interests were television and crossword puzzles. Other activity interests included bingo, movies, church, yahtzee and memory card games. The activity plan of care documented Resident #15 spoke the Spanish and English language, but preferred Spanish. Resident #15's activity participation record was reviewed for 30 days, between 9/16/24 and 10/16/24. The facility had initiated activity participation records including spiritual activities, outings, sensory activities, social activities, one on one visits, visits from friends and family, cognitive activities and creative activities. -The activity participation record failed to reveal any resident-centered Spanish activities were provided to Resident #15 between 9/16/24 and 10/16/24. II. Staff Interviews Certified nurse aide (CNA) #1 was interviewed on 10/15/24 at 10:11 a.m. CNA #1 said Resident #15 spoke Spanish and English. CNA #1 said Resident #15 did not need language services or activities in Spanish because he spoke English. Registered nurse (RN) #1 was interviewed on 10/16/24 at 8:41 a.m. RN #1 said there was no communication barrier between Resident #15 and staff because Resident #15 spoke English fluently. -However, despite CNA #1 and RN #1 indicating Resident #15 spoke English fluently and therefore did not need language services and activities in Spanish, the resident expressed that he preferred to receive activities in his preferred language of Spanish (see resident interview above). The activity director (AD) was interviewed on 10/17/24 at 1:14 p.m. The AD said her role was to engage the residents in activities that gave them purpose and meaning and kept them from being bored. She said she would ask the residents what they enjoyed doing and add their interests onto the activity calendar. She said she tried to find activities that were similar to the residents' past leisure pursuits. The AD said the activity program did not have activities specific for Spanish-speaking residents. She said once a year the facility celebrated Spanish heritage month. The AD said Resident #15 could speak, read and write in English. She said an activity for Spanish-speaking residents could have been created, however, she said nobody had expressed to her that it was a need. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD said she had access to Resident #15's care plan but she was not aware that he would want activities that were Spanish specific. She said she did not ask him if he wanted activities and/or reading materials in Spanish. She said he attended bingo, resident council meetings and Catholic church services. The AD said the activities Resident #15 attended were in English and he participated without concern. The director of nursing (DON) was interviewed on 10/17/24 at 10:27 a.m. The DON said there was no documentation that the facility had provided Resident #15 with activities in the Spanish language. The DON said she thought Resident #15 spoke fluent English. The DON said she was not aware Resident #15 wanted activities provided to him in the Spanish language. The DON said the facility had a language interpreter line available to staff if they needed to reach an interpreter for resident communication needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on interviews and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for four of ten resident rooms and one (#6) of two residents reviewed for accidents out of 26 sample residents, received adequate supervision to decrease and/or prevent risk for accident hazards. Specifically the facility failed to: -Ensure tap water in the facility was kept within a safe temperature range; -Initiate a timely fall care plan and interventions to prevent falls for Resident #6; and, -Ensure Resident #6's neurological assessments were completed after the resident sustained an unwitnessed fall in her room on 8/21/24. Findings include: I. Failure to ensure safe water temperatures A. Professional reference According to the Consumer Product Safety Commission (CPSC) Safety Alert, Avoiding Tap Water Scalds, retrieved on 10/23/24 from https://www.cpsc.gov/s3fs-public/5098-Tap-Water-Scalds.pdf, The majority of injuries and deaths involving tap water scalds are to the elderly and children under the age of five. The U.S. Consumer Product Safety Commission (CPSC) urges all users to lower their water heaters to 120 degrees Fahrenheit (F). B. Facility policy and procedure The Water Temperatures, Safety Of policy, revised December 2009, was provided by the nursing home administrator (NHA) on 10/17/24 at 4:17 p.m. The policy read in pertinent part, Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 112 degrees Fahrenheit (F) or the maximum allowable temperature per state regulation. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. Maintenance staff shall conduct periodic water temperature checks and record the water temperature in a safety log. C. Observations and resident interviews The tap hot water temperatures from resident rooms were obtained on 10/17/24 between 10:05 a.m. and 10:23 a.m. The hot water in each resident room ran for approximately one minute prior to taking the water temperature. The hot water temperatures were as follows: -At 10:17 a.m. the water temperature from the sink in room [ROOM NUMBER] was 131 degrees F. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The temperature gauges for the two facility hot water heaters were reviewed with the maintenance service director (MSD) at 3:42 p.m. The first hot water heater was located in the 100 hall. The hot water heater serviced the 100 hall (six) resident rooms. The temperature gauge of the hot water heater read 138 degrees F. The second hot water heater was located in the 400 hall and serviced the remainder of the facility rooms. The temperature gauge of the hot water heater read 140 degrees F. The tap hot water temperatures from resident room sinks and the one facility shower room were obtained on 10/17/24 between 3:50 p.m. and 4:00 p.m. The hot water temperature were as follows: -The shower room temperature registered 110 degrees F after one minute. -room [ROOM NUMBER] registered a hot water temperature of 130.8 degrees F after one minute. One resident who resided in room [ROOM NUMBER] said the water was hot and she was able to adjust the temperature with cold water, however, she said the staff usually helped her with everything she needed to do at the sink. The second resident who resided in room [ROOM NUMBER] said she had not had any problems with the hot water temperature from the sink. She said the water got warm but she was able to adjust the water temperature as needed. -room [ROOM NUMBER] registered a hot water temperature of 131 degrees F after one minute. The resident who resided in room [ROOM NUMBER] was bed bound. The resident said she did not use the sink in her room and the staff helped her with all of her activities of daily living (ADL) care. -room [ROOM NUMBER] registered a hot water temperature of 131.5 degrees F after one minute. The resident who resided in room [ROOM NUMBER] said he did not use the sink by himself. He said the staff would help him at the sink. D. Record review The resident room water temperature log was provided by the NHA on 10/17/24 at 4:17 p.m. The water temperature log documented water temperatures were taken weekly in random resident rooms, one to two rooms on each hall. Review of the resident room water temperatures from 9/19/24 to 10/14/24 revealed hot water temperatures ranged from 104 degrees F to 117 degrees F, excluding 10/2/24 when the hot water temperatures were documented as 75 degrees F (see interview below). E. Staff interviews The maintenance services director (MSD) was interviewed on 10/17/24 at 3:42 p.m. The MSD said hot water temperatures in resident rooms and the shower room should range between 100 degrees F and 112 degrees F. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Professional reference According to [NAME], P.A., [NAME], A.G., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 1780, retrieved on 10/21/24, In the event of a fall, perform a post-fall assessment to identify possible causes. Monitor patients closely for 48 hours after a fall. B. Facility policy The Fall Management System policy, dated June 2022, was obtained from the director of nursing (DON) on 10/17/24 at 10:57 a.m. It documented in pertinent part, A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, such as a resident pushing another resident, whether the event was witnessed or unwitnessed. The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without an injury is still a fall. The distance to the next lower surface is not a factor in determining if a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, it is still a fall. When a fall occurs, the resident is assessed for injury by the nurse. In the event a resident has a fall, and it has been determined they hit their head, or it cannot be determined if they hit their head (the fall was unwitnessed or the patient cannot verbalize if they hit their head), the nurse initiates the following actions: neurological checks are completed and documented per instructions. C. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included stroke, chronic obstructive pulmonary disease (COPD), and chronic kidney disease stage three. The 7/6/24 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. She was independent while eating, required substantial assistance with oral hygiene and was dependent on nursing staff for all other cares. D. Record review The fall care plan, initiated 8/26/24, documented that Resident #6 was a high fall risk. Interventions included anticipating resident needs, ensuring the resident's call light was within reach, educating the resident on what to do if a fall occurred, encouraging a helmet, which the resident frequently refused, encouraging the resident to participate in activities that promoted exercise, ensuring the resident was wearing appropriate footwear, placing a fall mat beside the resident's bed, providing a transfer pole beside the resident's bed and following the facility's fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall risk evaluation dated 2/5/24 documented the resident was at a high risk for falls. An interdisciplinary team (IDT) post fall review dated 2/5/24 documented Resident #6 experienced an unwitnessed fall on 2/5/24 at 1:24 a.m. -However, the facility failed to initiate a fall prevention plan of care and fall interventions until after the resident fell again on 8/21/24 (see care plan above). A fall risk evaluation dated 7/2/24 documented the resident was at a high risk for falls. A nurse progress note dated 8/21/24 documented that, at 4:10 p.m., Resident #6 was found on the floor and had reported she hit her head while trying to self-transfer. The progress note documented the DON and two certified nurse aides (CNA) asked Resident #6 if she hit her head and Resident #6 responded yes. The note documented the resident was able to express her concerns without issue. -Review of Resident #6's electronic medical record (EMR) did not reveal documentation which indicated neurological assessments were completed for the resident following her unwitnessed fall on 8/21/24. E. Staff interviews CNA #1 was interviewed on 10/15/24 at 3:41 p.m. CNA #1 said if a resident had an unwitnessed fall, she would get the nurse immediately to assess the resident while she obtained vital signs on the resident. CNA #1 said it was normal for nurses to perform neurological assessments frequently for 48 hours after a fall to ensure nothing happened to the resident. Registered nurse (RN) #1 was interviewed on 10/16/24 at 8:58 a.m. RN #1 said if a resident had an unwitnessed fall, the nurse would complete a neurological assessment and obtain vital signs. RN #1 said if a head injury was suspected or confirmed, neurological assessments would be performed on a regimented schedule for 48 hours. The DON was interviewed on 10/17/24 at 10:41 a.m. The DON said she was the nurse that responded when Resident #6 fell on [DATE]. The DON said ongoing neurological assessments were not completed for Resident #6 as part of the post-fall assessment. The DON said the ongoing neurological assessments should have been completed. The DON said that the facility had call light logs that were reviewed daily by the administration. The DON said longer call lights could contribute to an increase in the chance for falls. The DON said obtaining sufficient nurse staffing had been a difficulty for the facility. The DON said the facility was issuing more overtime to current nursing staff than before and administration had been covering night shifts on the floor to ensure appropriate nurse staff coverage. Cross-reference F725 for failure to provide sufficient nursing staff. The DON and the nursing home administrator were interviewed again on 10/17/24 at 6:32 p.m. The NHA said he knew call light response times were contributing to falls in the facility. The NHA said if a resident had to wait too long for help, the resident might get impatient and attempt to get up unassisted.

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F 0692 Level of Harm - Minimal harm or potential for 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** 50314 Based on observations, record review and interviews, the facility failed to ensure one (#6) of three residents reviewed out of 26 sample residents received the care and services necessary to meet their nutrition needs and to maintain their highest level of physical well-being. Specifically, the facility failed to: -Accurately obtain and document Resident #6's weights; and, -Weigh Resident #6 per physician's orders. Findings include: I. Facility policy and procedure The Nutritional Assessment policy, revised October 2017, was provided by corporate consultant (CC) #1 on 10/17/24 at 3:41 p.m. It documented in pertinent part, As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. II. Resident #6 A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included stroke, chronic obstructive pulmonary disease (COPD) and chronic kidney disease stage three. The 7/6/24 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. She was independent while eating, required substantial assistance with oral hygiene, and was dependent on nursing staff for all other cares. The assessment documented Resident #6 had no rejections of care. The assessment documented the resident was 65 inches (5 foot, 5 inches) tall. The assessment documented the resident weighed 253 pounds (lbs). The assessment documented the resident had not experienced weight loss in the last six months. B. Record review (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nutrition care plan, initiated on 8/26/16 and revised 1/11/2020, revealed Resident #6 and Resident #6's family were non-compliant with diabetes management and had received education previously. The care plan documented interventions included avoiding exposure to extreme heat or cold, to check the body for breaks in skin and provide treatment promptly, providing diabetes medications as ordered by the physician, providing a dietary consult for nutritional regimen and ongoing monitoring, discussing meal times and portion sizes, educating Resident #6 regarding the importance of dietary compliance, and educate Resident #6 and family as to the correct protocol for glucose monitoring and insulin injections. Resident #10's weights were documented in the electronic medical record (EMR) as follows: -On 4/28/24, the resident weighed 253.2 lbs; -On 5/6/24, the resident weighed 252.0 lbs; -On 6/2/24, the resident weighed 253.0 lbs; -On 9/18/24, the resident weighed 213.5 lbs; -On 9/27/24, the resident weighed 213.0 lbs; and, -On 10/7/24, the resident weighed 214.5 lbs. -The facility failed to accurately subtract the weight of the wheelchair on 4/28/24, 5/6/24 and 6/2/24 (see facility follow-up below). A review of physician's orders in the EMR revealed a physician's order to obtain Resident #6's weight weekly on Sundays for four weeks, then to obtain Resident #6's weight per facility protocol, ordered on 4/7/24 and discontinued on 10/14/24. -The facility failed to obtain and document Resident #6's monthly weight per physician's order in July 2024 and August 2024 . The 1/4/2020 comprehensive nutritional assessment documented Resident #6's admission weight was 257 lbs and Resident #6's usual body weight was 250 pounds. The 4/12/24 nursing at risk review note, dated 4/12/24, documented the resident was consistently eating less than 25% of all meals. The 6/20/24 nutritional assessment documented there were no significant changes with Resident #6's weight recently. The assessment documented the resident was consistently eating 75% to 100% of all meals. -The facility failed to accurately subtract the weight of the wheelchair on 4/28/24, 5/6/24 and 5/2/24 (see facility follow-up below). The 9/18/24 nursing at risk review note documented Resident #6 weighed 213.5 pounds. The note documented this was a weight gain from July 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, a review of the resident's EMR did not include documentation indicating the facility weighed the resident in July 2024. Facility weight performance improvement plan (PIP) documentation, dated 9/6/24, was provided by the director of nursing (DON) on 10/16/24 at 3:19 p.m. It documented that the facility identified a need to improve the accuracy of documented weights. It documented that education was provided to bedside nursing staff regarding appropriate equipment usage and documentation. III. Staff interviews The registered dietitian (RD) was interviewed on 10/17/24 at 11:46 a.m. The RD said she had been in her role for two months. The RD said that she was present in the building every other week on Wednesdays. The RD said that she created nutritional recommendations by interviewing staff on how the resident is doing, interviewing residents themselves, and by reviewing the electronic health record. The RD said when a resident experienced weight loss the care plan should be updated, the dietitian and family should be notified, and new interventions to reduce or prevent the weight loss should be put into place. The RD said she had an internal spreadsheet that tracked residents for which she had concern for weight loss or weight gain in the facility. The RD said Resident #6 was not identified as having a concern with weight loss. The director of nursing (DON) was interviewed on 10/17/24 at 12:20 p.m. The DON said she expected all residents to be weighed monthly unless there was a physician's order that indicated otherwise. The DON said Resident #6's weight loss was expected and the physician was aware of the weight loss. The DON said Resident #6 was not identified as having weight loss in interdisciplinary (IDT) team meetings. The DON said the facility had implemented a performance improvement plan for obtaining and documenting accurate resident weights in the facility on 9/6/24. -However, the facility provided additional documentation indicated t the weight discrepancy was because nursing staff inaccurately obtained and recorded Resident #6's weight on 4/28/24, 5/6/24, and 6/2/24 (see facility follow-up below). IV. Facility follow-up Additional documentation was received from the DON on 10/21/24 at 2:09 p.m. (after the survey). The facility documentation documented that Resident #6 had not experienced severe weight loss because the weights were obtained and recorded inaccurately. The facility documentation indicated Resident #6's wheelchair weighed 43.5 lbs and this was not correctly subtracted from weights recorded on 4/28/24, 5/6/24 and 6/2/24. The facility documentation indicated an additional weight was obtained in the month of July 2024. -However, no verification that this was completed was included in the submitted documentation. No verification of Resident #6's wheelchair weight was included in the submitted documentation or in the resident's EMR.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50314 Based on record review and interviews, the facility failed to provide sufficient nursing staff to ensure the residents received the care and services they required in a timely manner. Specifically, the facility failed to answer call lights in a timely manner for residents requesting staff assistance. Findings include: I. Facility policy The Staffing policy, revised October 2017, was provided by corporate consultant (CC) #1 on 10/17/24 at 3:41 p.m. The policy read in pertinent part, Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Other support services are also staffed to ensure that resident needs are met. II. Resident council meeting minutes The July 2024 resident council meeting minutes documented call lights were addressed as a concern. According to the meeting minutes, call lights were not always timely. The action item on the meeting minutes, the resident council was informed by the facility that some residents required two staff members for transferring, potentially taking the certified nurse aides (CNA) a little longer to answer the call lights. -The July 2024 resident council meeting minutes did not identify what the facility was going to do to address the residents' concern of untimely call light times. Cross reference F565 for failure to follow up on group grievances. III. Facility assessment The facility assessment, dated 10/1/24, was provided by the nursing home administrator (NHA) on 10/14/24 at 10:08 a.m. The facility assessment documented the care needs of 40 residents in the facility. The facility assessment documented that the 100 and 200 halls required one licensed nurse and two CNAs to care for the 18 residents residing on both halls during the day shift. It documented that the night shift on 100 and 200 halls also required one nurse and one CNA. It documented the 300 and 400 halls required one nurse and two CNAs to care for the 22 residents residing on both halls during the day shift. It documented the night shift on the 300 and 400 halls also required one nurse and one CNA. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility assessment documented that 18 residents required moderate assistance with personal hygiene and 14 residents required maximal assistance or were dependent on nursing staff for personal hygiene care. The assessment documented 21 residents required moderate assistance with bathing and 14 residents required maximal assistance or were dependent on nursing staff for bathing assistance. The assessment documented six residents required moderate assistance with their toileting program and 17 residents required maximal assistance or were dependent on staff for assistance with their toileting program. IV. Nursing staff time card and pay stub record review Nursing staff time cards and pay stubs were reviewed on 25 working days between 4/6/24 and 9/1/24. The review revealed the facility had only one bedside nurse working during the day shift on 4/6/24, 4/7/24, 4/21/24, 4/23/24, 5/20/24, 5/21/24, 5/27/24, 6/1/24, 6/9/24, 6/11/24, 6/29/24, 6/30/24, 8/30/24, 8/31/24 and 9/1/24. -However, the facility assessment documented the facility required two bedside nurses working during the day shift. -Additionally, the director of nursing (DON) said the facility required two bedside nurses working during the day shift (see DON interview below). V. Resident interviews Resident #8 was interviewed on 10/14/24 at 11:14 a.m. Resident #8 said she often had to wait 30 minutes to over an hour for her call light to be answered. Resident #8 said she and her roommate often requested help at the same time to get a more timely response from staff. Resident #8 said she waited most frequently in the afternoon for assistance. Resident #8 said she and many other residents had complained about slow call light response times to administration in the past but nothing had been done to improve call light response times. Resident #8 said she felt she was forgotten and unimportant to nursing administration. Resident #8 said the bedside nursing staff were working as hard as they could but they could not keep up with the residents' needs during the day. Cross-reference F565 for failure to follow up on group grievances. Resident #5 was interviewed on 10/14/24 at 2:12 p.m. Resident #5 said she often had to wait more than 30 minutes for staff to respond to her call light. Resident #5 said the nursing administration knew call light response times were slow but they were not doing anything to improve staffing in the facility. Resident #5 said she stopped using her call light as often if she felt she could do something independently. Resident #5 said she felt conflicted asking for help knowing other residents would not be cared for when she was offered assistance instead. Resident #28 was interviewed on 10/15/24 at 8:55 a.m. Resident #28 said he often waited more than 30 minutes for assistance from staff. Resident #28 said he required maximum assistance with most of his cares throughout the day. Resident #28 said he sometimes called for assistance before he actually needed it because he knew he would have to wait for a long time for the staff to come assist him. Resident #28 said he felt frustrated that nursing staff was always short staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #23 was interviewed on 10/15/24 at 9:22 a.m. Resident #23 said she had sometimes waited more than 30 minutes for assistance from staff on many occasions in the past month. Resident #23 said she thought the facility was purposely staffed with as few nurses and CNAs as possible. Resident #23 said she felt less important than a nickel when it took staff so long to assist her. Resident #6 was interviewed on 10/16/24 at 9:09 a.m. Resident #6 said she often waited more than 30 minutes for assistance from staff. Resident #6 said she did not like waiting more than 30 minutes for assistance. Resident #6 said waiting long periods of time for staff assistance happened more frequently at night for her. VI. Call light records from 10/2/24 to 10/16/24 Call light records were provided by the nursing home administrator (NHA on 10/16/24 at 6:11 p.m. A 14 day sample of call light response times, from 10/2/24 to 10/16/24, identified the following: On 10/2/24, a total of 200 resident call lights were turned on for resident assistance Bedside nursing staff required more than 15 minutes to respond to 40 of those call lights, representing 20% of all call lights turned on by residents for the day. On 10/3/24, a total of 150 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 32 of those call lights, representing 21.3% of all call lights turned on by residents for the day. On 10/4/24, a total of 126 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 23 of those call lights, representing 18.2% of all call lights turned on by residents for the day. On 10/5/24, a total of 141 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 23 of those call lights, representing 16.3% of all call lights turned on by residents for the day. On 10/6/24, a total of 162 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 14 of those call lights, representing 8.6% of all call lights turned on by residents for the day. On 10/7/24, a total of 163 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 32 of those call lights, representing 19.7% of all call lights turned on by residents for the day. On 10/8/24, a total of 144 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 19 of those call lights, representing 13.2% of all call lights turned on by residents for the day. On 10/9/24, a total of 167 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 16 of those call lights, representing 9.6% of all call lights turned on by residents for the day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24, a total of 162 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 29 of those call lights, representing 17.9% of all call lights turned on by residents for the day. On 10/11/24, a total of 169 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 35 of those call lights, representing 20.7% of all call lights turned on by residents for the day. On 10/12/24, a total of 122 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 21 of those call lights, representing 17.2% of all call lights turned on by residents for the day. On 10/13/24, a total of 144 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 19 of those call lights, representing 13.2% of all call lights turned on by residents for the day. On 10/14/24, a total of 147 resident call lights were turned on for resident assistance. Bedside nursing staff required more than 15 minutes to respond to 11 of those call lights, representing 7.5% of all call lights turned on by residents for the day. On 10/15/24, a total of 207 resident call lights were turned on for resident assistance. Bedside nursing staff responded to all call lights in 15 minutes or less on this day. On 10/16/24, a total of 130 resident call lights were turned on for resident assistance between midnight and 5:36 p.m. Bedside nursing staff required more than 15 minutes to respond to three of those call lights, representing 2.3% of all call lights turned on by residents during that time period. VII. Staff interviews The DON was interviewed on 10/17/24 at 10:27 a.m. The DON said it was normal to have two nurses working during the day and one nurse working at night. The DON said all of the nurses and CNAs in the facility were agency staff except for a few that were full time at the facility. The DON said she had experienced many difficulties in hiring staff at the facility.The DON said the cost of living where the facility was located presented a significant challenge for hiring staff. The DON said finding nursing coverage on all days and nights had been difficult for the facility. She said several administration staff, including herself, had worked night shift recently to ensure the facility had nursing coverage. The DON said the facility had seen an increase in the use of overtime hours for bedside staff recently. The DON said she had reviewed the resident call light logs provided to the survey team. She said call lights had been long recently and this was something the facility had been working on for several months. The DON said there was not an active and identified performance improvement plan regarding call light response time. The DON reviewed the resident call light log data for 10/15/24 and said she did not know why the facility recorded zero call lights over 15 minutes in length on that day. The DON said it was possible that additional administrative personnel, present for the survey, could have had a positive impact on call light response times seen during the recertification survey. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 10/17/24 at 6:32 p.m. The NHA said he knew call light response times were contributing to falls in the facility. The NHA said if a resident had to wait too long for help, they might get impatient and attempt to get up unassisted. Cross reference F689 for failure to prevent accidents/hazards.

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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. 40467 Based on resident interviews, staff interviews, and observations, 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. Specifically, the facility failed to consistently serve foods at a palatable texture. Findings include: I. Facility policy and procedure The Critical Temperatures for Safe Food Handling policy, undated, was provided by the dietary manager (DM) on 10/17/24 at 5:44 p.m. The policy read in pertinent part, Temperature should be taken periodically to assure hot food stays above 135 degrees Fahrenheit (F) and cold food stays below 41 degrees F during the serving process. Maintain a cold enough holding temperature to assure foods are maintained at or below 41 degrees F until they leave the service area. The Food and Nutrition Services Staff policy, undated, was provided by the DM on 10/17/24 at 6:21 p.m. The policy read in part, Food will be palatable, attractive and served in a timely manner at proper temperatures. II. Resident interviews Resident #28 was interviewed on 10/14/24 at 3:50 p.m. He said the food was not palatable. He said he ate in the dining room and the food was often served cold when it should be warm. He said he would eat a lot of sandwiches because he did not like being served cold food. Resident #39 was interviewed on 10/14/24 at 3:58 p.m. She said she ate in her room and food was often delivered to her cold. Resident #15 was interviewed on 10/14/24 at 5:17 p.m. He said he always ate his food in his room and was served cold food often. He said he was served cold food for breakfast on 10/14/24 and cold food for lunch on 10/13/24. III. Resident group interview A group interview was conducted on 10/16/24 at 10:32 a.m. with five alert and oriented residents (#2, #8, #15, #16 and #21) through facility and assessment. Four (#2, #8, #15, and #21) of the residents in the group interview said the food was served cooler than their preference. Resident #21 said he felt the dinner meals tended to be cold when he received the meal tray in his room. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 said she frequently saw the hot box mobile food cart door left open when staff served room trays. She said the food was served covered in plastic wrap instead of hard cover lids to maintain the heat. IV. Observations During a continuous observation of the dinner meal service on 10/16/24, beginning at 3:55 p.m and ending at 5:22 p.m., the following was observed: At approximately 4:35 p.m. cook (CK) #1 placed a container of garden salad on top of a container filled with ice and took the temperature of the salad. The garden salad registered a temperature of 41 degrees F. CK #1 said 41 degrees was the highest temperature the salad could be held at. At 4:43 p.m. meal service began and staff proceeded to cover room tray plates with plastic wrap and place them into the hot box mobile food cart. At 5:01 p.m. the hot box cart left the dining room for the room tray meal service. Between 5:02 p.m. and 5:08 p.m. the hot box cart door was left open while staff served room trays. The hot box cart was not plugged into an electrical outlet to maintain the heat of the meals trays left in the cart. A test tray for a regular diet was evaluated by two surveyors immediately after the last resident had been served their room tray for dinner on 10/16/22 at 5:23 p.m. The test tray consisted of vegetable pot pie and a garden salad with cheese, tomatoes and lettuce. The salad was served on the same plate as the pot pie. -The lettuce and tomatoes were slightly warm in touch and taste. The salad was 85.2 degrees F. -The vegetable pot pie was lukewarm. The vegetable pot pie was 107 degrees F. V. Staff interviews CK #1 was interviewed on 10/16/24 at 5:35 p.m. CK #1 said the garden salad was kept on ice until it was served to make sure it was served at a safe and palatable temperature. He said the salad had cheese on it and he would not want the salad to have a chance to grow bacteria if it was not kept at or below 41 degrees F. CK #1 said he would not want to eat a warm salad. He said the garden salad should have been kept cold. He said he hoped staff would not set the hot box food cart on the highest setting or plug in the hot box so the salad temperature would not rise too high while in the hot box with warm food. The DM was interviewed on 10/17/24 at 5:21 p.m. The DM said food could not be held in the danger zone to prevent bacteria growth. She said the temperature danger zone was a range of over 41 degrees F and under 135 degrees F. The DM said she wanted food to be held at between 145 degrees F and 165 degrees to make sure food was served warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/16/24 observations were reviewed with the DM. She said placing the garden salad in the hot box for room service would raise the temperature of the salad. She said the staff should have placed the salad in a container on ice during room service to help maintain the temperature for a cold salad. She said the cheese on the garden salad was dairy which could quickly become compromised with an increased temperature. The DM said hot foods such as the vegetable pot pie should be served at a warm palatable table. She said the hot box should be plugged in during room tray delivery and the door should be closed after each retrieval of a room tray and kept shut to maintain the temperature of the hot food items.

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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. 40467 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 safe and appropriate storage of food items in the pantry; and, -Ensure hand hygiene was conducted appropriately. Findings include: I. Failure to store food items appropriately in the the dry storage area A. Professional reference According to the United States Department of Agriculture (USDA) Is Food In Dented Cans Dangerous? (9/18/24) was retrieved on 10/22/24 from https://ask.usda.gov/s/article/Is-food-in-damaged-cans-dangerous, food from cans that were leaking, bulging, or badly dented should never be eaten. The damaged cans could contain clostridium botulinum (a toxic bacteria). B. Facility policy and procedure The Food and Nutrition Services Staff policy, undated, was provided by the dietary manager (DM) on 10/17/24 at 6:21 p.m. The policy read in pertinent part, The food service department is staffed by food and nutrition service personnel who have demonstrated the skills and competency to carry out functions of the department. Food and nutrition service staff under the supervision of the dietitian and or the food and nutrition service manager, will safely and effectively carry out all functions of the food and nutrition services department. C. Observations On 10/14/24 at 10:50 a.m. a can of garbanzo beans, a can of jalapeno peppers and two cans of tropical fruit were stocked on the first row and second rows of the can goods rack in the kitchen dry storage room. Each of the four cans of food had a dent on the side of the can. On 10/16/24 at 4:10 p.m. the dented can of jalapeno peppers remained on the shelf ready for use. The DM removed the can from the supply stock after she observed it. II. Failure to perform hand hygiene properly 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 - Some	The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 10/22/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The Center for Disease Control and Prevention (CDC) About Hand Hygiene For Patients in Healthcare Settings (2/27/24), retrieved on 10/22/24 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html, read in pertinent part, Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. According to the CDC, hand washing should occur before preparing or eating food, before touching the eyes, nose or mouth, and after touching potential contaminated surfaces. B. Observations During a continuous observation of the dinner meal service in the main kitchen on 10/16/24, beginning at 3:55 p.m and ending at 5:22 p.m., the following was observed: At 4:00 p.m. cook (CK) #1 performed hand hygiene, donned (put on) gloves and scooped chocolate pudding into dessert bowls. He wrapped the dessert bowls in plastic wrap to cover the top of the bowl. CK #1 removed his gloves and touched the back of his pants with his left hand, adjusted his face mask by touching the front surface of the mask, retrieved a marker, placed his left hand over each cover bowl to hold the plastic wrap tight as he dated each bowl with the marker in his right hand. -CK #1 did not perform hand hygiene after removing his gloves and prior to touching the pudding bowls. Between 4:36 p.m. and 5:05 p.m. CK #1 touched his face multiple times while preparing the meals. Without performing hand hygiene while he plated ready-to-eat resident meals of hamburgers, burritos and vegetable pot pie. At 4:52 p.m. CK #1 left the service line with gloved hands and opened and closed the walk-in refrigerator. With the same gloved hands he retrieved a block of plastic wrapped pre-sliced cheese. CK #1 unwrapped the cheese and removed a slice with the same gloved hands and placed the slice of cheese on a hamburger patty for a resident meal. CK #1 did not perform hand hygiene or change his gloves before he touched the slice of cheese. At approximately 5:00 p.m., CK #1 removed two tortillas from a bag. He placed one tortilla on the grill. CK #1 held the second tortilla in his hand as the tortilla touched the front surface of his apron before placing it on the grill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 5:12 p.m. CK #1 used the index finger of his gloved left hand to push his glasses closer to his face, without performing hand hygiene, he continued to plate meals III. Staff interviews CK #1 was interviewed on 10/16/24 at 4:05 p.m. CK #1 said all the cans of food in storage should be free from dents and punctures because of the risk of potential food poisoning. CK #1 was interviewed on 10/16/24 at 5:35 p.m. CK #1 said the garden salad was kept on ice until it was placed to make sure it was served at a safe and palatable temperature. He said the salad had cheese on it and he did not want the salad to have a chance to grow bacteria if it was not kept at or below 41 degrees F. He said the garden salad should have been kept cold. He said he hoped staff would not set the hot box food cart on the highest setting or plug in the hot box so the salad temperature would not rise too high while in the hot box with warm food. CK #1 said hand hygiene should be done every time he touched surfaces that were not food related. He said he should not open the refrigerator door and then touch food without hand hygiene. The registered dietitian (RD) was interviewed on 10/17/24 at 12:26 p.m. The RD said she had not provided education for the dietary staff or kitchen oversight in the two months she had been at the facility but would welcome the opportunity. The DM was interviewed 10/17/24 at 5:21 p.m. The DM said CK #1 needed to have something put in place so his glasses so he would not continue to adjust them during meal service with his gloved hands. The DM said hand hygiene should be conducted every time a potentially contaminated surface touched gloved hands during meal preparation and service. She said she would review the facility ' s hand hygiene protocol with CK #1. She said food she not touch potentially contaminated surfaces such as CK #1 apron. The DM said she was the one who would usually put away food cans on the supply shelf and make sure there were no dents on the cans. She said for a short time she was not available to put away the cans on the shelf so the other dietary staff placed the food cans on the shelf after the cans were delivered to the facility. The DM said she had not provided education to staff not to put away cans with dents on the shelf because she was usually the one who did it. She said she would create an education, informing the dietary staff of risk of food borne illnesses to the residents from dented cans. She said dents in the can could break the seal of the can causing potential contamination of the food inside the can. The DM said she would establish a routine check of the food can stock.

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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. 50314 Based on 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 developement and transmission of infectious diseases. Specifically, the facility failed to offer COVID-19 vaccinations and provide COVID-19 vaccination information to Resident #28, Resident #12, Resident #5 and Resident #17. Findings include: I. Facility policy and procedure The Coronavirus Disease (COVID-19) - Vaccination of Residents policy, revised May 2023, was provided by corporate consultant (CC) #1 on 10/17/24 at 3:41 p.m. It documented in pertinent part, Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. The resident or resident representative has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee. Residents are screened for contraindications to the vaccine, medical precautions, and proper vaccination before being offered the vaccine. II. Record review A review of Resident #28's electronic medical record (EMR) revealed no documentation indicating the resident was not eligible for a COVID-19 vaccination. A review of Resident #28's mEMR revealed no documentation that the resident was offered the COVID-19 vaccination or that COVID-19 vaccination education was provided to the resident. A review of Resident #12's EMR did not reveal documentation indicating the resident was not eligible for a COVID-19 vaccination. A review of Resident #12's EMR revealed no documentation that the resident was offered the COVID-19 vaccination or that COVID-19 vaccination education was provided to the resident. A review of Resident #5's EMR did not reveal documentation indicating the resident was not eligible for a COVID-19 vaccination. A review of Resident #5's EMR revealed no documentation indicating the resident was offered the COVID-19 vaccination or that COVID-19 vaccination education was provided to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #17's EMR did not reveal documentation indicating the resident was not eligible for a COVID-19 vaccination. A review of Resident #17's EMR revealed no documentation indicating the resident was offered the COVID-19 vaccination or that COVID-19 vaccination education was provided to the resident. III. Staff interviews The director of nursing (DON) was interviewed on 10/17/24 at 11:39 a.m. The DON said that there was no documentation indicating the COVID-19 vaccinations was offered to Resident #28, Resident #12, Resident #5 and Resident #17. The DON said the facility had not offered Resident #28, Resident #12, Resident #5 and Resident #17 the COVID-19 vaccination or COVID-19 vaccination education in the last calendar year. The infection preventionist (IP) was interviewed on 10/17/24 at 2:13 p.m. The IP said she had been in the IP role for two months. The IP said she was not involved in managing vaccinations in the facility and resident vaccination tracking was being completed by the DON. The IP said she did not know if any COVID-19 vaccinations had been offered to residents in the facility. The IP said it was important to provide vaccine education to residents so they could understand the side effects and benefits of that medical decision. The DON was interviewed again on 10/17/24 at 4:11 p.m. The DON said she had identified that the facility needed to do more to offer vaccines to residents in the facility and had begun the process of discussing flu and pneumonia vaccines with residents. The DON said the facility had not initiated a performance improvement plan regarding offering residents COVID-19 vaccinations. The DON said she was not aware of medical contraindications to the COVID-19 vaccine for Resident #28, Resident #12, Resident #5 or Resident #17.