STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure four (#1, #8, #7 and #27) of 11 residents reviewed for abuse out of 28 sample residents were kept free from abuse. Resident #2 was admitted to the facility on [DATE] with diagnoses of cerebral palsy (disease that affects movement and muscle tone), acute respiratory failure, dementia with behavioral disturbance, violent behavior, depression, need for assistance with personal care and cognitive communication deficit. Resident #2's care plan documented he had potential to demonstrate physically and verbally aggressive behaviors due to his diagnosis of dementia. The resident had exhibited aggression toward staff and other residents. On 11/3/24, Resident #8 reported to staff that his roommate, Resident #2, had hit him. Resident #8 was assessed and found to have a bruise under his right eye. Resident #2 told staff that he swung at Resident #8. Resident #8 was sent to the emergency department (ED) where he was treated for bruising and swelling to his face and returned to the facility the same day. On 1/19/25, screaming was heard in Resident #2's room. Resident #2 and Resident #1 were found lying on the floor, both on their right side. Resident #1 was behind Resident #2. Resident #1 had a large bruise and swelling to her left eye, bleeding from her mouth and facial redness and discoloration. Resident #2 stated that he beat up Resident #1. Resident #1 was transported to the hospital and admitted with trauma to the head and neck where she was monitored for agitation and tachycardia (high heart rate). Resident #1 was readmitted to the facility on [DATE] with bruising to the face, chest and neck. Additionally, the facility failed to protect Resident #7 and Resident #27 from verbal abuse by Resident #4. Findings include: I. Facility policy and procedure (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Abuse Prevention and Reporting-Guideline policy, revised August 2021, was provided by the nursing home administrator (NHA) on 1/27/25 at 11:49 a.m. It read in pertinent part, Residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the residents family members or legal guardians, friends, or other individuals. All allegations of abuse are investigated. Verbal abuse is any use of oral, written or gestured language that includes knowingly threatening a resident causing fear or imminent, serious bodily injury within hearing distance, to described residents, regardless of their age, ability or disability to comprehend. Physical abuse is the intentional action of inflicting bodily injury including, but not limited to hitting, slapping, pinching or kicking. It also includes unreasonable confinement, restraint, and bruises of unknown origin. The administrator or designee will complete the investigation and will notify the suspected assailant and victim or responsible party of the conclusions and any corrective actions implemented based on investigative findings. II. Incidents of physical abuse of Resident #1 and Resident #8 by Resident #2 A. Facility incident reports of physical abuse of Resident #8 and Resident #1 The NHA provided investigations for the incidents of abuse of Resident #8 and Resident #1 on 1/28/25 at 3:00 p.m. The investigations documented the following: On 11/3/24, Resident #8 reported to staff that his roommate, Resident #2, had hit him. Resident #8 was assessed by facility staff and found to have a bruise under his right eye. Resident #2 told staff that he swung at Resident #8 because Resident #8 did not want to go to sleep. Resident #8 was permanently moved to a different room and Resident #2 was placed on one-on-one facility staff supervision and no longer had a roommate. After an 11/4/24 physician evaluation, it was determined Resident #8 should be sent to the emergency department where he was treated for bruising and swelling to his face and returned to the facility the same day. On 11/9/24 Resident #2 was documented as having been on 15-minute checks after one-on-one facility staff supervision was discontinued. On 1/19/25, screaming was heard in Resident #2's room. Resident #2 and Resident #1 were found lying on the floor, both on their right side and Resident #1 was behind Resident #2. Resident #1 had a large bruise and swelling to her left eye, bleeding from her mouth and facial redness and discoloration. When questioned, Resident #2 stated that he beat up Resident #1 because she wandered into his room. Resident #1 and Resident #2 were immediately separated and Resident #1 was sent to the hospital for further evaluation and treatment. Resident #1 was transported to the hospital and admitted with trauma to the head and neck and was readmitted to the facility on [DATE] with bruising to the face, chest and neck. Resident #2 was placed on one-on-one facility staff monitoring and discharged to the hospital on 1/19/25 with right hand discoloration to his knuckles and fourth and fifth digits. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Oakwood Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 W 1st Ave Lakewood, CO 80226	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	B. Resident #2 (assailant) 1. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on 1/19/25. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral palsy, acute respiratory failure, dementia with behavioral disturbance, violent behavior, depression, need for assistance with personal care and cognitive communication deficit. The 1/24/25 minimum data set (MDS) assessment revealed the resident was moderately impaired regarding tasks of daily life and cues and supervision were required per staff assessment. A review of the residents electronic medical record (EMR) documented, on 10/22/24, the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of six out of 15. The 1/24/25 assessment documented Resident #2 needed substantial to maximum assistance with oral hygiene, bathing, dressing and bed mobility. He needed set up assistance with eating. The MDS assessment documented the resident had physical and verbal behaviors directed at others. 2. Record review Resident #2's comprehensive care plan, initiated 7/16/24, documented the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to his dementia diagnosis. Pertinent interventions, initiated 7/16/24, included to monitor, document and report to the physician or a nurse any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing himself, difficulty understanding others, level of consciousness and mental status. Resident #2's focused care plan for verbally aggressive behaviors related to dementia, initiated 9/5/24 and revised 11/9/24, documented Resident #2 acted in a playful way toward other residents which could be misconstrued. Pertinent interventions included to document the resident's behavior and attempted interventions (initiated 9/6/24 and revised 11/9/24), and analyzing key times, places, circumstances, triggers and what de-escalated the resident's behavior and document; the resident responded to verbal interventions from staff, was placed in a private room (with no roommate) and had potential for unprovoked aggression towards others. -The playful behaviors which could be misconstrued however, were not specified or documented. Resident #2's focused care plan for physical behaviors, initiated 11/4/24, documented he had the potential to demonstrate physical behaviors related to dementia, had exhibited aggression toward staff and other residents and was placed in a private room (with no roommate). (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Pertinent interventions, initiated 11/4/24, included to document observed behavior and attempted interventions, monitor, document and report to the physician if the resident was a danger to himself and others, and analyze key times, places, circumstances, triggers and what de-escalated the behaviors and document the findings.

A review of Resident #2's EMR documented the following:

On 7/17/24 provider documentation revealed Resident #2 was previously admitted to a hospital in April 2024 after assaulting an individual at a previous facility and being verbally abusive to the staff prior to admission to the current facility on 7/16/24.

-However, the facility failed to implement a care plan that addressed Resident #2's behavior history upon his admission to the facility.

Cross reference F744 for failure to provide a person centered dementia services.

On 7/18/24 a nursing progress note, written at 3:55 p.m., documented Resident #2 approached multiple residents screaming and cursing at them for no reason. The staff directed Resident #2 away from the other residents and offered Resident #2 food and conversation. The assistant director of nursing (ADON) and on-call provider were notified.

Cross reference F609 for failure to report abuse to the State Agency.

On 7/19/24 a nursing progress note, written at 5:01 a.m,. documented Resident #2 was extremely aggressive and agitated throughout the shift and was calling residents names using explicit language and overall disrupting the normal nightly routines. Other residents were fearful of Resident #2 during this shift. Resident #2 began stalking residents and trying to physically trip other residents with his feet. Multiple interventions were attempted without effectiveness and a non-emergent message was left with the director of nursing (DON).

-However, the incidents on 7/17/24, 7/18/24 and 7/19/24 were not reported to the NHA, who was the facility's abuse coordinator.

On 7/19/24 a nursing progress note, written at 6:01 p.m., documented Resident #2 was extremely agitated throughout the shift and was using profanity. Resident #2 began following other residents and trying to trip them with his feet but did not make contact and was more than ten feet away from the other residents.

-The facility failed to document attempted interventions to redirect the resident or if the physician was notified.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/13/24 a nursing progress note, written at 2:27 a.m., documented Resident #2 continued to wander on the secure memory care unit needing one-on-one facility staff care due to increased aggressive behavior and attempting to go in and out of other residents' rooms. After Resident #2 was redirected away from other residents' rooms, the resident held a closed fist up to staff while swinging and yelling profanities. Several residents got up and returned to their room, as they appeared afraid. Reassurance was given to residents redirected by staff back to their rooms. Resident #2 continued on one-on-one facility staff monitoring for resident safety. The facility placed a call to the provider to send the resident to the ED for evaluation and the ADON was notified. On 8/13/24 at 6:31 p.m. the DON documented a clarification note that indicated the DON followed up and Resident #2 was not yelling at any specific residents but residents were redirected into their rooms related to loud noise from Resident #2. On 8/16/24 a nursing progress note, written at 12:42 p.m., documented Resident #2 was observed in his wheelchair propelling in the hallway and yelling profane names at the female residents as they walked by. Resident #2 was then observed kicking and banging on a resident's door, while yelling and cursing at the female resident on the other side of the door. The resident was redirected to a quiet area, and listened to the staff member, appeared disinterested, verbalized understanding then laughed. On 10/9/24 a provider note documented the staff reported ongoing behaviors of Resident #2 attempting to interact with other residents in a playful manner, which could be irritating to other residents, and providing verbal redirection was usually sufficient. On 10/10/24 a nursing progress note, written at 11:47 a.m., documented Resident #2 was screaming at another resident in the hallway. Staff intervened and separated both residents safely. The resident was redirectable and went to participate in activities. -The facility failed to document the interventions used to redirect the resident or if the physician was notified. On 10/11/24 at 5:53 a.m. a nursing progress note documented Resident #2 continued to scream at a resident and staff and needed to be redirected multiple times. The nurse continued to monitor the resident's behaviors. -The facility failed to document attempted interventions to redirect the resident or if the physician was notified. The 11/4/24 physician note, documented at 7:26 a.m., revealed the physician followed up with Resident #2 regarding the resident assaulting and punching his roommate, and the resident had not had this type of behavior before and had intermittent verbal altercations with staff. -However, previous documentation revealed Resident #2 had previously used profane and derogatory language directed at other residents as well as kicking and banging another resident's door and cursing at her while she was in her room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/8/24 a nursing progress note, written at 5:31 p.m., documented Resident #2 had multiple outbursts, yelling obscenities at staff and other residents. Resident #2 was at times able to be redirected, and this was reported to the DON. -The facility failed to document attempted interventions to redirect the resident or if the physician was notified. On 1/19/25 at 5:20 p.m. a certified nurse aide (CNA) heard screaming from resident Resident #2's room and notified a registered nurse (RN). Upon entering the room, Resident #2 was found on his right side on the floor and Resident #1 was lying on her right side behind him. Resident #1 had a large bruise and swelling to her left eye as well as bleeding from her mouth and facial redness/discoloration. Resident #2 said that he beat up Resident #1 because she wandered into his room. C. Resident #8 (victim) 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, chronic respiratory failure, emphysema, depressive episodes, cognitive communication deficit and the need for assistance with personal care. The 1/1/25 MDS assessment revealed the resident was cognitively impaired with a BIMS score of two out of 15. Resident #8 required substantial to maximal assistance with toileting hygiene, bathing and lower body dressing, moderate assistance with personal hygiene and transfers, and supervision with eating. The MDS assessment documented Resident #8 had physical and behavioral symptoms directed toward others. 2. Record review Resident #8's behavior care plan, revised 4/3/24, documented the resident had potential to become verbally and physically aggressive toward others related to dementia and Alzheimer's disease. The care plan indicated his triggers were not understanding his surroundings and others approaching him from behind or not in his line of vision. Pertinent interventions, initiated 3/14/24, included if the resident could not be redirected or calmed, and if safe to do so, staff were to attempt to perform cares at a later time after the resident was calm, offering a deck of cards and staff to approach the resident within his line of vision. Interventions added on 11/11/24 included to approach the resident from the front or make it known you were approaching, redirect the resident and/or offering the resident a deck of cards. D. Resident #1 (victim) 1. Resident status (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Resident #1, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included early onset Alzheimer's disease, severe dementia, bipolar disorder, anxiety disorders, and psychotic disorder with hallucinations.

The 1/1/25 MDS assessment revealed the resident had a memory problem and was severely impaired, never or rarely making decisions per staff assessment. Resident #1 was dependent on care or needed substantial to maximal assistance for all activities of daily living (ADL), used a wheelchair, was independent with eating and transferring self and required set up assistance with showering.

The MDS assessment documented the resident had behaviors that were not directed at others.

2. Record review

Resident #1's behavior care plan, revised 10/15/24, documented she had potential for a behavior problem related to her Alzheimer's diagnosis, schizoaffective disorder, bipolar type, psychotic disorder with hallucinations, and behavioral exacerbations as evidenced by wandering tendencies through the unit and into others' rooms. Resident #1 presented with periods of affection towards others.

Pertinent interventions, initiated 3/1/24, included to document the resident's behaviors and resident response to interventions. Additional interventions, initiated 1/24/25, included to offer Resident #1 a safe wandering area and provide a quiet environment. The facility added a personalized shadow box outside her room so she could easily identify her room. Upon return from the hospital (on 1/24/25) Resident #1 was monitored for 72 hours to determine a pattern of behaviors and wandering.

E. Staff interviews

Licensed practical nurse (LPN) #3 was interviewed on 1/28/25 at 11:25 a.m. LPN #3 said when Resident #2 was asleep alone in his room, he would at times wake up screaming, yelling and throw his wheelchair and other belongings around the room. LPN #3 said Resident #2 was easily redirectable and if he said Resident #2's name, the resident would immediately change his behavior. LPN #3 said Resident #2 sometimes wandered and he reported the resident's behaviors to the physician. LPN #3 said Resident #2 verbally lashed out at other residents. LPN #3 said he was able to redirect the resident's behavior by saying his name and asking the resident to be a gentleman. LPN #3 said he never witnessed Resident #2 have physical contact with another resident. LPN #3 said when Resident #2 had behaviors, it usually happened very quickly and nothing specific triggered the resident's behaviors.

LPN #3 said the facility conducted abuse education and he knew to contact the NHA to report abuse. LPN #3 said if he was unable to reach the NHA, he would contact the DON and the ADON to report abuse.

The DON and the NHA were interviewed together on 1/29/25 at 11:00 a.m. The DON said the 24-hour nursing report was reviewed daily in the morning meeting. The DON said a note in a resident's EMR could be marked, by the writer, to enable the note to be viewed in the 24 hour report.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said when an agency staff member worked at the facility, the facility staffing coordinator provided the agency staff member information that included the DON's and the NHA's phone numbers. The DON said the facility was working on assembling an information and orientation packet for agency staff that included what incidents to report and whom to report to. The DON said the facility identified agency staff were working when Resident #2's behaviors were not accurately documented or reported. The NHA said after interviewing staff after the 1/19/25 incident between Resident #2 and Resident #1, the staff reported they heard the residents in Resident #2's room, and the residents (Resident #2 and Resident #1) were both lying on the floor. The NHA said the staff reported Resident #1 was behind Resident #2, holding him. The DON said both Resident #2 and Resident #1's behaviors were not observed to be out of the ordinary on 1/19/25. The DON said the regional clinical resource (RCR) interviewed the staff about the incident on 1/19/25 and staff reported both residents were baseline. The DON said a stop sign was placed on Resident #2's door in November 2024 to discourage other people from going in his room. The DON said Resident #2 did not like other people in his room. The DON said Resident #1 wandered into Resident #2's room but she was unsure if Resident #1 was able to understand the stop sign. The DON said it took time to become familiar with a resident's baseline behavior, which was why Resident #2 did not have a behavior care plan upon admission to the facility. The DON said if a new resident was admitted to the facility, the facility reviewed the resident's referral packet and resident's PASRR (pre admission screening and resident review) documentation and if behaviors were listed the facility put them into the care plan. The DON said the facility tried to establish a baseline for a residents' behavior and then determine if there were specific resident behaviors that needed to be added to a care plan. The NHA said he was the abuse coordinator for the facility and the staff were to call him to report allegations or suspicions of abuse. The NHA said if staff were not able to reach him, the next person to call was the DON, and if staff were unable to call the DON they could call the ADON. The NHA said he expected staff to call him to report abuse and not text him. The RCR and the DON were interviewed together on 1/29/25 at 3:00 p.m. The RCR said the facility's documentation of Resident #2's behaviors could have been more specific when describing if the behaviors were directed to a specific resident or not. The RCR said Resident #2 would be in his room and fine by himself and then could escalate quickly with no warning. The DON said Resident #2 had his medications adjusted in the latter part of 2024 which seemed to be more beneficial to the resident and his behaviors decreased. The DON said Resident #2 was triggered by people wandering into this room. The RCR said after reviewing the documentation in Resident #2's record, the facility recognized the documentation errors in the resident's EMR primarily originated from agency staff. She said after the incident on 1/19/25, the facility implemented a plan to only schedule facility staff in the secured unit (where Resident #1, Resident #2 and Resident #8 resided) instead of agency staff. The RCR said facility staff knew the residents better, could better anticipate a resident's needs and recognize if a resident's behavior began to change and intervene before the behavior escalated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The RCR said part of the plan of correction implemented after 1/19/25 was to create cards for the staff in memory care so staff could access, on the card, immediate and specific interventions for each resident. She said the cards were made for staff to carry on their person. The RCR said the staff found the cards helpful. The RCR said the plan of correction included ongoing monitoring of the memory care unit for at least a three-month period, which would be reviewed monthly in the facility's quality and performance improvement (QAPI) meetings. F. Facility plans of correction and follow up The NHA provided plans of correction (POC) on 1/30/25 at 3:20 p.m. for the incidents on 11/3/24 and 1/19/25. 1. POC for incident between Resident #2 and Resident #8 The POC for the 11/3/24 incident between Resident #2 and Resident #8 included: -A chart review for Resident #2 completed on 11/6/24 by the medical director with medication recommendations; -Resident #1 returned to the facility with bruising that was monitored and resolved with no complications and offered psychosocial support; -Resident #2 was started on immediate one-to-one staff to resident monitoring; -A chart review and identification of residents on the secure unit on 11/11/24 to ensure residents had appropriate care plans with identified triggers; -A chart review for roommate evaluation to ensure all roommate situations were working; -Monitoring initiated 11/13/24 to 1/24/25 that included observation of the secure unit to identify if any resident behaviors were happening and if staff responded appropriately; -Staff interviews three times a week to determine if they knew residents' triggers and interventions; and, -The DON or designees educated all staff who worked on the secured unit regarding resident's specific triggers. (However, the education was not dated). 2. POC for the incident between Resident #2 and Resident #1 The POC for the 1/19/25 incident between Resident #2 and Resident #1 included: -Resident #2 was put on one-to-one staff to resident monitoring until emergency responders transported the resident to the emergency department; -A review of all residents on the secure unit and five residents were identified who wandered and IDT reviewed their care plans; (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

-The DON provided education to staff who provided direct care of potential triggers and interventions for each resident in the secure unit on 1/21/25;

-An audit of the secure unit, initiated 1/25/25, that included five residents three times a week, that included review of resident behaviors, interventions and staff observations of appropriate staff response to resident behaviors;

-Resident #1 was monitored for 72 hours upon return to the facility;

-A consultation with an abuse preventionist coordinator about triggers and interventions; and,

-Results of the audit would be presented in QAPI until substantial compliance was met.

-However, the POC was complete as the facility had additional allegations of physical and verbal abuse that were not addressed (see below).

50219

III. Incident of verbal abuse by Resident #4 toward Resident #27 on 7/24/24

The facility incident report, dated 7/25/24 at 9:05 p.m., was provided by the NHA on 1/28/25 at 3:00 p.m. The report revealed Resident #4 arrived at the 400 unit seeming upset on 7/24/24 at 9:15 p.m. Resident #4 began yelling at staff members who attempted to de-escalate the resident and direct him away from the common area and other residents. During these attempts, Resident #4 said things about Resident #27 and the nurse present was not sure if Resident #27 heard what Resident #4 was saying about her. Resident #4 was eventually able to be redirected to his room. Resident #27 was assessed and interviewed and did not recall hearing anything or that an incident occurred. Resident #4 was placed on cares in pairs and one-to-one supervision until his behaviors improved. Both residents received psychosocial monitoring. Resident #4 was also placed on a success plan.

A. Resident #4 (assailant)

1. Resident status

Resident #4, age 66, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the December 2024 CPO, diagnoses included multiple sclerosis, depressive episodes, muscle weakness, and thyrotoxicosis (a disorder in which the thyroid gland produces too much thyroid hormone).

The 12/23/24 MDS assessment revealed the resident was cognitively intact and was independent with making decisions regarding tasks of daily life. The resident was dependent for most activities of daily living.

The assessment indicated that the resident exhibited verbal behavioral symptoms directed towards others one to three days out of the assessment period.

2. Record review

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Oakwood Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 5301 W 1st Ave Lakewood, CO 80226	

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 0600 Level of Harm - Actual harm Residents Affected - Few	The trauma care plan, initiated 3/30/24 and resolved 5/23/24, revealed Resident #4 was at risk for retraumatization due to a history of trauma. Pertinent interventions included engaging with mental and behavioral health support and medication management, approaching in a calm manner, administering medications as ordered, discussing behavior and attempting to de-escalate and implement coping strategies and praising any indication of progress/improvement in behavior. The personality disorder care plan, initiated 3/30/24, revealed Resident #4 had a potential for mood problems due to his personality disorder which included anger and emotional outbursts, slamming objects down and using profanity. Pertinent interventions initiated 3/30/24 included administering medications as ordered, behavioral health consults as needed, encouraging the resident to express his feelings, de-escalating the resident, assisting him to a quieter or less stimulating environment, assisting him to an outdoor space for fresh air and medication. Interventions initiated on 5/6/24 included a success plan and encouraging the resident to ask for assistance when unable to perform ADLs independently. Interventions initiated on 7/25/24 included having the resident on one-to-one supervision. The behavior problem care plan, initiated 3/6/24, revealed Resident #4 had the potential for a behavior problem resulting from his personality disorder and depression. Pertinent interventions initiated on 3/7/24 included having caregivers provide an opportunity for positive interaction and attention, encouraging the resident to use his call light, intervening as necessary to protect the rights and safety of others, praising any indication of progress or improvement in behavior and a success plan. The verbal behavior care plan, initiated 3/7/24, revealed Resident #4 had the potential to demonstrate verbally aggressive behaviors due to anger and his personality disorder, which included swearing and using racially-insensitive language. Pertinent interventions initiated on 3/7/24 included a success plan analyzing key times, places, circumstances, triggers, and what de-escalated the behavior and documenting that information, giving the resident choices for care and activities, encouraging the resident to sit outside or watch funny videos online when upset or angry. Interventions initiated on 5/6/24 included a success plan in which the resident would ask for assistance from staff when he was having problems with his peers or removing himself from interactions with peers by going outside or to his room. Interventions initiated on 7/24/24 included a one-to-one companion and success plan. The behavior problem care plan, initiated 3/30/24, revealed Resident #4 had a potential for behavior problems due to his depression and personality disorder. A Level II PASSAR was conducted and found no significant mental illnesses. Pertinent interventions included the following PASRR recommendations: assisting with transitional housing, providing psychiatric case consultation, providing rehabilitation services and providing management. A practitioner note, dated 4/17/24 at 3:13 p.m., revealed Resident #4 was initially admitted from a previous facility where he had been hospitalized for three months due to psychiatric issues involving aggressive behavior. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 7/24/24 at 6:03 p.m., revealed Resident #4 was roaming up and down the hallways screaming about the food at the facility, using profanity, and disrupting other residents. The facility staff tried to redirect Resident #4 but he began targeting the staff with verbal aggression. The staff stopped engaging with Resident #4 except to politely ask him to discontinue his verbal aggression but were ineffective. The DON, the NHA, and the social services director (SSD) were notified of Resident #4's behaviors. A progress note, dated 7/25/24 at 12:29 a.m., revealed Resident #4 continued to use obscene and racially-insensitive language toward staff members. Resident #4 requested to be transferred to the emergency room , but when paramedics arrived, Resident #4 refused to go with them. Resident #4 then called emergency services throughout the night until he fell asleep. The DON, the NHA, and the SSD were notified of his behavior. B. Resident #27 (victim) 1. Resident status Resident #27, age 70, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, anxiety disorder, dementia and cognitive communication deficits. The 10/25/24 MDS assessment revealed the resident was significantly cognitively impaired with a BIMS score of three out of 15. The resident was independent for most activities of daily living. 2. Record review The behavior care plan, revised 4/24/24, revealed Resident #27 had[TRUNCATED]

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47151

Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification agency in accordance with state law for two (#2 and #24) of 11 residents reviewed for abuse out of 28 sample residents.

Specifically, the facility failed to report incidents of potential verbal and physical abuse involving Resident #2 and Resident #24 to the State Survey Agency (SSA).

Findings include:

I. Facility policy and procedure

The Abuse Prevention and Reporting-Guideline policy, revised August 2021, was provided by the nursing home administrator (NHA) on 1/27/25 at 11:49 a.m. It read in pertinent part, It is the policy of this facility that all allegations of abuse are investigated. Residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation. Verbal abuse is any use of oral, written or gestured language that includes knowingly threatening a resident causing fear or imminent, serious bodily injury within hearing distance, to described residents, regardless of their age, ability or disability to comprehend. Physical abuse is the intentional action of inflicting bodily injury including, but not limited to hitting, slapping, pinching, kitchen, etc. It also includes unreasonable confinement, restraint, and bruises of unknown origin. The administrator or designee will complete the investigation and will notify the suspected assailant and victim or responsible party of the conclusions and any corrective actions implemented based on investigative findings.

II. Resident #2

A. Resident status

Resident #2, age greater than 65, was admitted on [DATE] and discharged on [DATE] to the hospital. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral palsy (disease that affects movement and muscle tone), acute respiratory failure, dementia with behavioral disturbance, violent behavior, depression, need for assistance with personal care and cognitive communication deficit.

The 1/24/25 minimum data set (MDS) assessment revealed the resident was moderately impaired regarding tasks of daily life and cues and supervision were required per staff assessment. A review of the residents electronic medical record (EMR) documented on 10/22/24 the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of six out of 15.

The assessment documented Resident #2 needed substantial to maximum assistance with oral hygiene, bathing, dressing, and bed mobility. He needed set up assistance with eating.

The MDS assessment documented the resident had physical and verbal behaviors directed at others.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review A review of Resident #2's electronic medical record (see below) and interviews with the interdisciplinary team (IDT) revealed facility staff incorrectly documented resident to resident altercations involving Resident #2 or failed to report the incidents to the facility abuse coordinator according to the interventions on Resident #2's care plan. These incidents occurred from 7/19/24 until 10/11/24, prior to Resident #2's altercations on 11/3/24 with Resident #8 and 1/19/25 with Resident #1. Resident #2's focused care plan for verbally aggressive behaviors related to dementia, initiated 9/5/24 and revised 11/9/24, documented Resident #2 acted in a playful way toward other residents which could be misconstrued. Pertinent interventions included to document the resident's behavior and attempted interventions (initiated 9/6/24 and revised 11/9/24), and analyze key times, places, circumstances, triggers and what de-escalated the resident's behavior and document; the resident responded to verbal interventions from staff, was placed in a private room (with no roommate) and had potential for unprovoked aggression towards others. -The playful behaviors, which could be misconstrued, were not specified or documented. Resident #2's focused care plan for physical behaviors, initiated 11/4/24, documented he had the potential to demonstrate physical behaviors related to dementia, had exhibited aggression toward staff and other residents and was placed in a private room (with no roommate). Pertinent interventions initiated 11/4/24 included to document observed behavior and attempted interventions, monitor, document and report to the physician if the resident was a danger to himself and others, and analyze key times, places, circumstances, triggers and what de-escalated the behaviors and document the findings A review of Resident #2's EMR revealed the following documented incidents: On 7/18/24 a nursing progress note, written at 3:55 p.m., documented Resident #2 approached multiple residents screaming and cursing at them for no reason. Staff directed Resident #2 away from other residents. The assistant director of nursing (ADON) and on-call provider were notified. -The facility was unable to provide documentation that the incident had been investigated for potential abuse or that the incident of potential abuse was reported to the State Agency. On 7/19/24 at a nursing progress note written at 5:01 a.m. documented Resident #2 was extremely aggressive and agitated throughout the shift and was calling residents names using explicit language and overall disrupting the normal nightly routines. Other residents were fearful of Resident #2 during this shift. Resident #2 began stalking residents and trying to physically trip other residents with his feet. A non-emergent message was left with the director of nursing (DON). -The facility was unable to provide documentation that the incident had been investigated for potential abuse or that the incident of potential abuse was reported to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 a nursing progress note, written at 6:01 p.m., documented Resident #2 was extremely agitated throughout the shift and using profanity. Resident #2 began following other residents and trying to trip them with his feet but did not make contact and was more than ten feet away from the other residents. -The facility was unable to provide documentation that the incident had been investigated for potential abuse or that the incident of potential abuse was reported to the State Agency. On 8/13/24 a nursing progress note, written at 2:27 a.m., documented Resident #2 continued to wander on the secure memory care unit needing one-to-one facility staff care due to increased aggressive behavior and attempting to go in and out of other residents' rooms. After Resident #2 was redirected away from residents' rooms, Resident #2 held a closed fist up to the staff and was swinging and yelling profanities. Several residents got up and returned to their room as they appeared afraid. Reassurance was given to those residents redirected by staff back to their room. Resident #2 continued on one-to-one monitoring for resident safety. The facility placed a call to the provider to send the resident to the emergency department (ED) for evaluation and the ADON was notified. On 8/13/24 at 6:31 p.m. the DON documented a clarification note indicating the DON followed up and the resident was not yelling at any specific residents but residents were redirected into their rooms related to loud noise from Resident #2. -The facility was unable to provide documentation that the potential abuse was reported to the State Agency. On 10/10/24 a nursing progress note, written at 11:47 a.m., documented Resident #2 was screaming at another resident in the hallway. Staff intervened and separated both residents safely. The resident was redirectable and went to participate in activities. -The facility was unable to provide documentation that the incident had been investigated for potential abuse or that the incident of potential abuse was reported to the State Agency. On 10/11/24 a nursing progress note, written at 5:53 a.m., documented Resident #2 continued to scream at a resident and staff and needed to be redirected multiple times. The nurse continued to monitor the resident's behaviors. -The facility was unable to provide documentation that the incident had been investigated for potential abuse or that the incident of potential abuse was reported to the State Agency. III. Resident #24 A. Resident status Resident #24, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included dementia without behavioral disturbance, high blood pressure, muscle weakness and unsteadiness on his feet. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/20/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of two out of 15. Resident #24 required substantial to maximal assistance with bathing, dressing and personal hygiene. He needed set up assistance for meals and was independent with walking up to 150 feet. The MDS assessment documented Resident #24 wandered and the behavior occurred on one to three days during the review period. B. Record review Resident #24's elopement care plan, initiated 8/16/24, documented he exhibited wandering behavior and resided in the secure unit of the facility due to exit seeking behavior. Pertinent interventions included to document wandering behavior and attempted diversional interventions. Resident #24's self care performance care plan, initiated 8/13/24, documented an activities of daily living (ADL) performance deficit related to his diagnoses of dementia, hyperlipidemia and high blood pressure. Pertinent interventions initiated 8/14/24 included that the resident required one to two staff members for transfers, toileting, repositioning and turning in bed. C. Incident involving Resident #24 and Resident #2 on 12/11/24 A review of Resident #2's EMR documented in a behavior note on 12/11/24 at 5:00 a.m. that at approximately 7:00 p.m. on 12/10/24 staff heard a whimpering noise and a male voice call out saying Get out of here. The staff approached Resident #2's room and observed Resident #2 standing over Resident #24 laying on a metal box spring bedframe in a fetal position. Resident #24 was observed with visible fresh blood from his left eye area/eyebrow, as well as a skin tear to the top of his left hand. Resident #2 said he did not want this male resident in his room or to get in bed with him, and Resident #24 was assisted to a standing position and assisted back to his room ambulating with his walker. Resident #2 said that he felt bad and was sorry, and that he was a nice person. The ADON was notified who then notified the DON. On 12/11/24 a progress note, written at 10:22 a.m., documented a clarification note which indicated there was no physical altercation between the residents (Residents #2 and Residents #24). On 12/11/24 at 12:26 p.m. a provider documented Resident #2 was seen at the request of nursing staff. Nursing staff reported that on the evening of 12/10/24 another resident (Resident #24) laid in the empty bed in Resident #2's room resulting in a resident to resident altercation. On exam this morning (12/11/24) Resident #2 was found lying in his bed alert, calm, and was in no acute distress. Upon seeing the provider enter the room Resident #2 immediately said I am not going to hurt anyone anymore and that he was sorry. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #24's EMR revealed a provider note on 12/11/24 at 12:27 p.m. documented Resident #24 was seen by the provider at the request of nursing and as a follow up to a resident to resident altercation in which Resident #24 was the victim. A laceration was noted over Resident #24's left eyebrow and left hand of the resident. Emergency medical services was called with concern that Resident #24 needed sutures. Paramedics attended to small lacerations and did not feel hospital transfer was necessary at that time. During the exam on 12/11/24, Resident #24 was found lying in his bed alert, calm, in no acute distress with a social smile. Resident #24 reported chronic back pain but otherwise denied pain and was able to verbalize he was hurt by someone but denied being afraid. The resident had a small linear scabbed laceration noted over his left eyebrow and a linear scabbed laceration to his left hand with steri-strips in place. -The facility was unable to provide documentation that the incident of potential abuse was reported to the State Agency, and interviews revealed the facility documented the incident as a fall by Resident #24 (see interviews below). IV. Staff interviews The DON and the NHA were interviewed together on 1/29/25 at 11:00 a.m. The DON said the 24-hour nursing report was reviewed daily in the morning meeting. The DON said a note in a resident's EMR could be marked, by the writer, to enable the note to be viewed in the 24-hour report. The DON said the some of the documented incidents in Resident #2's EMR might not have been checked to show in the 24-hour report, making it more difficult to see and review them, so incorrectly documented notes were not followed up on. The NHA and the DON said that incidents on 7/18/24 and 7/19/24 in Resident #2's EMR (see above) should have been reported to the abuse coordinator and the State Agency. The NHA and the DON said they did not see the notes documented on 7/18/24 and 7/19/24. The DON and the NHA said the documented incident on 10/11/24 in Resident #2's EMR should have been reported to the State Agency. The NHA said the facility did not shy away from reporting to the appropriate agencies. The NHA said the facility documented the incident on 12/22/24 between Resident #2 and Resident #24 as a fall because during their investigation, Resident #24 stated he fell . The NHA said Resident #24 was interviewed about the incident in the presence of Resident #2. The NHA said Resident #2 was always truthful about his behavior. The NHA said both residents (#2 and #24) said there was no physical contact and the facility did not have reason to doubt that or they would have reported it. The DON said that Resident #2 had been truthful in the past when he had an altercation with another resident and they believed Resident #2 to be truthful about the incident on 12/11/24. -However, based on the provider documentation, Resident #24 stated post incident on 12/11/24 he was hurt by someone, and Resident #2 said he was not going to hurt anyone anymore and he was sorry. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she was not aware the provider documented on 12/11/24 that Resident #24 had told the provider someone hurt him until 12/16/24. The DON said she did not know why the provider who documented Resident #24's statement on 12/11/24 did not immediately report to the facility. The DON said she asked that the provider's documentation be amended based on the facility's investigation revealing Resident #24 had a fall. The DON said when an agency staff member worked at the facility, the facility staffing coordinator provided the agency staff member information that included the DON's and the NHA's phone numbers. The DON said the facility was working on assembling an information and orientation packet for agency staff that included what incidents to report and whom to report to. The DON said the facility identified agency staff were working when Resident #2's behaviors were not accurately documented or reported. The regional clinical resource (RCR) was interviewed on 1/29/25 at 3:00 p.m. The RCR said after reviewing the documentation in Resident #2's record, the facility recognized the documentation errors in the resident's EMR primarily originated from agency staff. She said after the incident on 1/19/25, the facility implemented a plan to only schedule facility staff in the secured unit (where Residents #1, #2 and #8 resided) instead of agency staff. The RCR said facility staff knew the residents better, could better anticipate a resident's needs and recognize if a resident's behavior began to change and intervene before the behavior escalated.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one (#2) of five residents reviewed for mood and behavior out of 28 sample residents. Specifically, the facility failed to a implement person-centered care plan upon admission to address Resident #2's history of physical aggression towards others in order to prevent physical altercations with other residents. Findings include: I. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged on [DATE] to the hospital. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral palsy (disease that affects movement and muscle tone), acute respiratory failure, dementia with behavioral disturbance, violent behavior, depression, need for assistance with personal care and cognitive communication deficit. The 1/24/25 minimum data set (MDS) assessment revealed the resident was moderately impaired regarding tasks of daily life and cues and supervision were required per staff assessment. A review of the residents electronic medical record (EMR) documented on 10/22/24 the resident had severe cognitive impairments with a brief interview for mental status score (BIMS) of six out of 15. The 1/24/25 assessment documented Resident #2 needed substantial to maximum assistance with oral hygiene, bathing, dressing, and bed mobility. He needed set up assistance with eating. The MDS assessment documented the resident had physical and verbal behaviors directed at others. II. Record review The 7/17/24 provider note documented in Resident #2's EMR revealed the provider documented that Resident #2 was previously admitted to a hospital in April 2024 after assaulting an individual at a facility and being verbally abusive to the staff prior to admission to the facility on [DATE]. Resident #2's comprehensive care plan, initiated 7/16/24, documented the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to his dementia diagnosis. Pertinent interventions, initiated 7/16/24, included to monitor, document and report to the physician or a nurse any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing himself, difficulty understanding others, level of consciousness and mental status. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility did not implement any person centered interventions related to the resident's history of physical and verbal aggressions. Resident #2's focused care plan for verbally aggressive behaviors related to dementia, initiated 9/5/24 and revised 11/9/24, documented Resident #2 acted in a playful way toward other residents which could be misconstrued. Pertinent interventions included to document the resident's behavior and attempted interventions (initiated 9/6/24 and revised 11/9/24), and analyzing key times, places, circumstances, triggers and what de-escalated the resident's behavior and document; document observed behavior and attempted interventions; the resident responded to verbal interventions from staff, was placed in a private room (with no roommate) and had potential for unprovoked aggression towards others. -The playful behaviors which could be misconstrued however were not specified or documented in Resident #2's care plan. -The verbally aggressive behavioral care plan was not implemented until 9/5/24, two months after the resident was admitted to the facility with a history of physical aggression. Resident #2's focused care plan for physical behaviors, initiated 11/4/24, documented he had the potential to demonstrate physical behaviors related to dementia, had exhibited aggression toward staff and other residents and was placed in a private room (with no roommate). Pertinent interventions initiated 11/4/24 included to document observed behavior and attempted interventions, monitor, document and report to the physician if the resident was a danger to himself and others, and analyze key times, places, circumstances, triggers and what de-escalated the behaviors and document the findings. -However, the facility failed to update Resident #2's care plan with effective interventions to prevent resident to resident abuse and behaviors upon his admission to the facility based on his documented history behaviors. Cross-reference F600: failure to prevent abuse III. Staff interviews The director of nursing (DON) and nursing home administrator (NHA) were interviewed together on 1/29/25 at 11:00 a.m. The DON said when an agency staff member worked at the facility, the facility staffing coordinator provided the agency staff member information that included the DON's and the NHA's phone numbers. The DON was interviewed on 1/29/25 at 3:00 p.m. The DON said Resident #2 did not immediately have specific behaviors added to his care plan upon admission as the facility tried to establish a baseline for a resident's behavior first. She said the facility would determine if it was a behavior that needed to be care planned. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 1/29/25 at 3:30 p.m. The SSD said Resident #2's behavior could escalate quickly with no warning. The SSD said when Resident #2 was talking loudly, it was difficult to determine which behaviors might be directed at staff and which behaviors might be directed at residents. The SSD said the facility monitored Resident #2's behaviors because they were sporadic and it was difficult to identify a trend in his behaviors. The regional clinical resource (RCR) was interviewed on 1/29/25 at 3:00 p.m. The RCR said after reviewing the documentation in Resident #2's record the facility recognized the documentation errors in the resident's EMR primarily originated from agency staff. She said after the incident on 1/19/25 the facility implemented a plan to only schedule facility staff in the secured unit where Resident #2 resided The RCR said facility staff knew the residents better, could better anticipate a resident's needs and recognize if a resident's behavior began to change and intervene before the behavior escalated.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

47151

Based on interviews, observations and record review, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value, were palatable in taste and temperature.

Specifically, the facility failed to ensure the residents' food was palatable in temperature.

I. Facility policy and procedure

The Timely Meal Service and Food Temperature policy, undated, was provided by the nursing home administrator (NHA) on 1/30/25 at 4:00 p.m. It read in pertinent part, Food will be delivered promptly to ensure safe, palatable and high-quality food served at the proper temperature. Food will be served at preferable temperatures (hot foods hot and cold foods cold) as discerned by the patients/residents and customary practice (not to be confused with proper holding temperatures).

II. Resident interviews

Resident #28 was interviewed on 1/27/25 at 11:47 a.m. Resident #28 said the food was bad.

Resident #10 was interviewed on 1/27/25 at 3:27 p.m. Resident #10 said food was often served cold and the facility seemed to run out of common food items.

Resident #3 was interviewed on 1/28/25 at 11:15 a.m. Resident #3 said every once in a while her food arrived warm to her room, otherwise the food was always cold.

Resident #16 was interviewed on 1/28/25 at 11:20 a.m. Resident #16 said the food was not

being prepared properly, because they microwaved the vegetables. She said the food was always served cold.

III. Observations

During a continuous observation on 1/27/25, beginning at 11:30 a.m. and ending at 1:54 p.m., the following was observed during the meal preparation and service in the main kitchen:

The posted menu was breaded Italian chicken, penne pasta with marinara, basil zucchini saute and frosted spice cake.

At 1:20 p.m. assembly of resident meal trays for the 400 hall room delivery started.

At 1:24 p.m. the facility ran out of zucchini and cooked broccoli to serve for the remainder of the meal.

At 1:37 p.m. the test tray was assembled and placed in the 400/700 hall room delivery cart. The test tray was covered with a room delivery base instead of a plate cover or insulated dome lid.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:43 p.m. the first room tray was delivered to a resident in the 400 hall. The cover had partially fallen off the test tray leaving the food exposed. At 1:51 p.m. the room delivery cart was transported to unit 700 for room delivery. The test tray was partially uncovered leaving the food exposed. At 1:53 p.m. the test tray was removed from the cart. The test tray was immediately evaluated by four surveyors after the last resident had been served their room tray for lunch. The test tray consisted of a breaded chicken breast, penne pasta with marinara sauce, broccoli and cake for dessert. -The broccoli was 102 degrees F. -The chicken breast was 120 degrees F -The penne pasta was 102 degrees F The cake did not have icing and the pasta was overcooked and soggy. IV. Staff interviews The dietitian resource (DR) was interviewed on 1/29/25 at 1:00 p.m. The DR said the plates used for the 400 hall room trays, including the test tray, were not placed in the plate warmer prior to meal assembly. The DR said plates placed in the plate warmer were used for room trays and the plates left on the shelf at room temperature were usually used for the dining room. The DR said the facility did purchase another case of plates (during the survey) so this would not happen again and ensured the plate warmer always had hot plates for room tray service. The DR said she spoke with the dietary staff after meal service and the staff reported to her they do not typically run out of plate covers and lids. The DR said it was possible that not all plate covers and lids were returned to the kitchen after breakfast that morning. The DR said they should have enough plate covers and lids for lunch in case the meal trays are not all returned after breakfast. The DR said she updated the facility dietary improvement plan initiated in October 2024 to include food temperatures. V. Facility follow up The dietary improvement plan, October 2024 was provided by the DR on 1/29/25 p.m. at 2:00 p.m. The plan was updated to include the following correction action items of food temperatures: purchase more plates, to ensure all food items were covered and to utilize two steam tables for meal service. -However, additional plates were not purchased until the survey (1/27/25 to 1/29/25).

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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 - Some	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** 50219 Based on observations and interviews the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and in three of five nourishment rooms. Specifically, the facility failed to ensure safe and appropriate storage of food items in the kitchen and three of five nourishment room refrigerators. Findings include: I. Professional reference The Colorado Retail Food Establishment Rules and Regulations, (3/16/24), retrieved on 2/4/25 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 3-25) Medicines that require refrigeration and are stored in a food refrigerator shall be stored in a package or container and kept inside a covered, leakproof container that is identified as a container for the storage of medicines (Chapter 7-207.12) II. Facility policy and procedure The Foods Brought by Family or Visitor/Personal Food Storage, undated, was provided by the nursing home administrator (NHA) on 1/30/25 at 3:00 p.m. It read in pertinent part, Food or beverage brought in from outside sources for storage in facility pantries or refrigeration units will be monitored by designated facility staff for food safety. III. Observations On 1/27/25 at 11:05 a.m. the following was observed in the main kitchen refrigerator: -Four sealed containers of deli-style potato salad, with use by dates of 1/7/25; -A plastic package of hot dogs, unsealed and dated 1/20/25; -A plastic squeeze bottle containing an unidentified sauce, unlabeled and undated; -Two thawed and individually wrapped raw pork roasts in a clear lexan container. There were no pull dates or expiration dates on the product package or container; and, -Two thawed, individual packages of an orange liquid in a clear container. There were no pull dates or expiration dates on the product package or container. On 1/27/25 at 11:50 a.m. an open bottle of burgundy cooking wine, with an expiration date of 12/13/23 was observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25 at 11:10 a.m. the following was observed in the drink station refrigerator: -Commercially packaged apple slices with an expiration date of 1/1/25. The package was swollen and bloated; -A slice of cake on a plate in the freezer, unwrapped and unlabeled; -A container of yogurt, with an expiration date of 12/18/24; -A container of yogurt, with an expiration date of 1/18/25; -A container of yogurt, with an expiration date of 1/6/25; -A container of cottage cheese, with an expiration date of 1/24/25; -Five pitchers of juice, unlabeled and undated; -Two containers of milk, with a sell-by date of 11/15/24; and, -The refrigerator and freezer had multiple spills of brown liquid and crumbs throughout. On 1/27/25 at 11:50 a.m. the following was observed in the 400 hall nourishment refrigerator and freezer: -A frozen pasta [NAME] in the freezer, with a best-before date of July 2024. There was no resident name or date written on the package; -One package of corn tortillas with 9/27 written on the package; -One bag of fresh grapes. There was no resident name or date written on the package; -One half-full jar of green chile sauce. There was a name on the jar but no open date; and, -Two containers of fresh fruit, each dated 1/23/25. A sign on the 400 hall nourishment refrigerator documented the following: food left past 72 hours would be thrown away. Dietary staff would check food daily and food would be thrown away if there was no name or date or if it was past the three-day limit or best-by date. No exceptions. Food must be labeled with the date, resident name and room number and tightly covered. On 1/28/25 at 11:05 a.m. the items observed in the 400 hall nourishment refrigerator and freezer on 1/27/25 were still present. On 1/27/25 at 12:34 p.m. the following was observed in the 500 hall nourishment refrigerator butter conditioner (a shelf on the inside of the door to the refrigerator with a clear cover): -One dose of Prevnar vaccine labeled with a resident name in a sealed plastic bag; and, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two doses of tuberculin vaccine labeled with a resident name in a sealed plastic bag. The butter conditioner had a plastic lid that did not completely seal off the contents of the container and did not have any labels or indications that medications were to be stored there. On 1/28/25 at 4:44 p.m. the vaccines (see above) were no longer in the 500 hall nourishment refrigerator. IV. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 1/28/25 at 11:07 a.m. LPN #2 said the jar of green chile (see above) belonged to the resident whose name was on the jar. LPN #2 said she would discard the jar of green chile because it did not have a date written on it, but the printed date on the jar was in 2026. -LPN #2 discarded the jar of green chile. The dietitian resource (DR) was interviewed on 1/29/25 at 1:00 p.m. The DR said it was the responsibility of all the dietary staff to pay attention to the food labels. The DR said the staff should write a pull date on the item when it was removed from the freezer. The DR said typically the label should be put on the tray or container instead of the product itself because the label did not adhere well to the product packaging. The DR said the dietary staff had previously been instructed how to date and label. The DR said cleaning unit refrigerators were on the dietary staff checklist to be completed every week. The DR said the nourishment refrigerators were managed by dietary staff. The DR said if a family member brought in personal food items for a resident, then the staff member who received that food, such as a CNA, was responsible for dating and labeling the food prior to putting the food in the nourishment refrigerators. The director of nursing (DON) was interviewed on 1/29/25 at 1:00 p.m. The DON said medications were not typically stored in the nourishment refrigerators and were removed from the nourishment refrigerator. 47151

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51916 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on one of six units. Specifically, the facility failed to ensure facility staff followed enhanced barrier precautions (EBP) when performing high contact activity with Resident #12, who had a suprapubic catheter and stage 4 (damage extending through all skin layers, reaching underlying muscle, tendon or bone, often with exposed tissue and high risk of infection) pressure wounds. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions in Nursing Homes, updated 7/12/22, retrieved on 2/3/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care (any skin opening requiring a dressing). II. Facility policy and procedure The Infection Prevention and Control Program (IPCP) On Standard and Transmission-Based Precautions policy, revised April 2024, was provided by the nursing home administrator (NHA) on 1/30/25 at 3:11 p.m. It revealed in pertinent part, In long term care (LTC), it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident. Therefore it is appropriate to use the least restrictive approach possible that adequately protects the resident and others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP are used in conjunction with standard precautions (infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status, including hand hygiene, environmental cleaning and disinfection, injection/medication safety, risk assessment with use of appropriate personal protective equipment based on performed activities, minimizing potential exposures, respiratory hygiene, and reprocessing of reusable medical equipment) and expand the use of PPE through the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of multidrug resistant organisms (MDROs) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. The use of gown and gloves for high contact resident care activities is indicated when contact precautions (transmission-based precautions, or TBP, used with known infection that is spread by direct or indirect contact with the resident or resident's environment) do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of known MDRO infection or colonization and those with MDRO infection or colonizations. Wounds include, but are not limited to, chronic wounds, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical devices include, but are not limited to, central venous catheters, peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes and tracheostomies. III. Observations On 1/27/25 at 10:15 a.m. an initial observation of unit four was conducted. A droplet precaution (infection control measures used to prevent the spread of respiratory infections) sign was observed on Resident #12's door. His door was open. There was a PPE bin outside of the room. Resident #12 was resting in bed. Resident #12 had an indwelling suprapubic catheter and stage 4 pressure injuries. During a continuous observation of unit four on 1/27/25, beginning at 11:17 a.m. and ending at 2:00 p.m., the following was observed: At 11:17 a.m. the droplet precaution sign had been removed from Resident #12's door and the PPE bin was no longer outside the resident's room. -There was no EBP sign on Resident #12's door or a PPE bin outside the resident's room, was identified by the director of nursing (DON) as the facility's process for making staff aware of which residents required EBP (see DON interview below). At 1:09 p.m. the physical therapist (PT) was observed going into Resident #12's room and asking the resident if he was ready for some exercise.The PT performed hand hygiene and closed the resident's door. -The PT did not put on PPE prior to entering the resident's room to do physical therapy with the resident. At 1:42 p.m. the speech language pathologist (SLP) performed hand hygiene, knocked on Resident #12's door and entered the resident's room. -The SLP did not put on PPE prior to entering the resident's room to do speech therapy with the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PT was still in the resident's room and was adjusting the resident's wheelchair footrests while the resident was sitting up in his chair. The PT, who was not wearing PPE, performed hand hygiene and left the resident's room after the SLP entered the room. -There was no used PPE observed in the resident's trash receptacle to indicate the PT had followed EBP during Resident #12's physical therapy session. During a continuous observation on 1/28/25, beginning at 10:02 a.m. and ending at 1:00 p.m, the following was observed: At 10:02 a.m. Resident #12 was resting in bed and his catheter bag was observed hanging at the foot of the bed. -There was no PPE bin outside of the resident's room and no EBP sign was on the door, which was identified by the DON as the facility's process for making staff aware of which residents required EBP (see DON interview below). At 11:21 a.m. certified nurse aide (CNA) #1 entered Resident #12's room to reposition and toilet him. -CNA #1 donned (applied) gloves but failed to put on a gown before he provided care. CNA #2 entered Resident #12's room with the mechanical lift, shortly after CNA #1, and washed her hands. -CNA #2 did not put on a gown before entering the resident's room but donned gloves once she entered. CNA #1 and CNA #2 provided perianal care to the resident without donning gowns. The resident had a wound dressing on his right ischium (bone in the pelvis that forms the lower and back part of the hip) wound that was pulling up along the edges. The dressing had visible serosanguineous drainage (yellowish-white drainage with streaks of blood) on it. IV. Staff interviews CNA #2 was interviewed on 1/28/25 at 3:53 p.m. CNA #2 said she was not familiar with any special infection precautions required for Resident #12. CNA #1 was interviewed on 1/28/25 at 3:57 p.m. CNA #1 said he was unaware of any need to wear any special PPE, except for gloves, when performing cares for Resident #12. CNA #3 was interviewed on 1/29/25 at 1:10 p.m. CNA #3 said she only knew of one resident on the unit with a catheter (Resident #12) but she had never seen staff donning PPE during the resident's care except for the wound care team when they changed his wound dressing. The assistant director of nursing (ADON) was interviewed on 1/29/25 at 1:40 p.m. The ADON said he understood if someone had an infection, they would place the appropriate sign on the door as well as a PPE bin to alert staff. The staff utilized the PPE when toileting and helping residents perform activities of daily living (ADL). The ADON did not verbalize understanding of how and why EBPs were utilized or initiated for residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 1/29/25 at 2:46 p.m The DON said if a resident was on EBP there should be a sign on the resident's door as well as a bin with PPE outside the resident's room. She said Resident #12 should have had an EBP sign on his door and a PPE bin outside his room to alert staff of his high infection risk status. The regional clincial resource (RCR) was interviewed on 1/29/25 at 2:52 p.m. The RCR said she was made aware that Resident #12 was missing an EBP sign and a PPE bin outside of his room to alert staff of his EBP status. She said her plan was to immediately correct this by providing a sign and alerting the nurses to use appropriate PPE when providing high contact care for the resident. She said the facility would conduct an EBP audit (process of reviewing and evaluating a facility's compliance with EBP), including staff education and training. The ADON was interviewed a second time on 1/29/25 at 3:10 p.m. The ADON said he initially removed the droplet precautions sign and PPE bin from Resident #12's door on 1/27/25 because the resident had no current active infections and he was uninformed about EBP. He said staff were made aware of the residents who were on EBP via signage, PPE bins and morning meeting reports. The ADON said he would be more vigilant about ensuring the EBP measures were maintained in the future.