STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065253	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Villa Grande Care Center	2501 Little Bookcliff Dr Grand Junction, CO 81501

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#15) of one resident out of 37 sample residents. Specifically, the facility failed to ensure an assessment was conducted to determine whether the self-administration of medications was clinically appropriate for Resident #15. Findings include: I. Facility policy and procedure The Self-Administration of Medications policy and procedure, revised February 2021, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. It revealed in pertinent part, As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Residents who are identified as being able to self-administer medications are asked whether they wish to do so. II. Resident #15 A. Resident status Resident #15, age greater than 65 was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included gastro-esophageal reflux disease (GERD) and osteoporosis. The 5/16/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required moderate assistance with toileting, bathing, dressing and set up assistance with eating and oral hygiene. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident observation and interview On 5/21/25 at 9:35 a.m. during the medication administration observation, a medication cup with one chewable tablet was observed on Resident #15's bedside table. Registered nurse (RN) #3 said Resident #15 frequently requested her scheduled Calcium Carbonate chewable tablet to be left at the bedside to take at a later time. When RN #3 attempted to administer the scheduled Calcium Carbonate chewable tablet, Resident #15 declined and requested to leave one tablet on the bedside table. RN #3 left the Calcium Carbonate in a cup on Resident #15's bedside table and exited the room. Resident #15 was interviewed on 5/21/25 at 5:03 p.m. Resident #15 said some staff at the facility did not allow her to keep the Calcium Carbonate chewable tablets at her bedside, but she said most of the nurses did. She said she preferred to have the medication available after her meals. Resident #15 said she was not aware of an assessment being conducted to determine if she was able to safely administer her own medications. C. Record review A review of Resident #15's May 2025 CPO revealed the following physician's order: Calcium Carbonate chewable tablet 500 milligrams (mg) by mouth three times daily, ordered 3/7/24. The May 2025 medication administration record (MAR) revealed RN #3 documented Resident #15's scheduled dose of Calcium Carbonate chewable tablets as administered. Cross reference F759: the facility failed to ensure the medication error rate was less than five percent. -A review of Resident #15's electronic medical record (EMR) did not reveal documentation to indicate that an assessment had been conducted to determine if Resident #15 was able to safely administer her own medication. -The EMR did not reveal a physician's order for Resident #15 to self-administer the Calcium Carbonate and approval for it to be kept at the resident's bedside. III. Staff interviews RN #3 was interviewed on 5/21/25 at 9:35 a.m. RN #3 said Resident #15 had worked in healthcare in the past and was particular about taking the Calcium Carbonate chewable tablet with her meals. RN #3 said she felt it was safe for Resident #15 to administer this medication on her own, but she said she could not recall if a formal assessment for self-administration of medications was previously completed. RN #1 was interviewed on 5/22 at 12:08 p.m. RN #1 said he would leave medications such as eye drops or nasal spray at a resident's bedside upon request if the resident was physically capable of self-administering medications and cognitively able to understand how and why to take the medication. RN #1 said he was aware the facility had a policy to allow residents to self-adminster medications, but he said he could not recall if a specific assessment was required. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) and the corporate consultant (CC) were interviewed together on 5/22/25 at 4:01 p.m. The DON said if a resident requested to self-administer medications, a self-administration assessment should be completed by a nurse. She said the physician should be notified and a physician's order obtained for the resident to self-administer medications. She said the resident's comprehensive care plan should be updated to show the resident was assessed and determined to be safe self-administering medication. The DON said she did not think a medication self-administration assessment had been completed for Resident #15. The DON said the nurses must witness a resident consuming a medication in order to document it as administered in the resident's MAR.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. Based on observations and interviews, the facility failed to ensure residents received notices orally and in writing which included a written description of their legal rights. Specifically, the facility failed to ensure the State Survey Agency (SSA) contact information, including the phone number, address and email address were posted and in a manner accessible and understandable to all residents. Findings include: I. Resident group interview A group interview was conducted on 5/21/25 at 10:00 a.m. with five residents (#14, #52, #64, #66 and #77) who were deemed interviewable through the facility and assessment. All five of the residents said they were not aware they could contact the SA and did not know where to get the SA's contact information. II. Observations On 5/21/25 at 9:50 a.m., a walk-through of the facility was conducted and did not reveal a posting for the SA's contact information, to include the agency's phone number, address and email address. III. Staff interview The nursing home administrator (NHA) was interviewed on 5/21/25 at 11:15 a.m. The NHA confirmed the required SA contact information was not posted in the facility.

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F 0600 Level of Harm - Minimal harm or potential for 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** Based on observations, record review and interviews, the facility failed to ensure two (#68 and #71) of seven residents out of 37 sample residents were kept free from abuse. Specifically, the facility failed to: -Prevent an altercation between Resident #68 and Resident #71; -Protect Resident #68 from physical abuse by Resident #65; and, -Protect Resident #71 from physical abuse by Resident #68. Findings include: I. Facility policy and procedure The Abuse, Neglect, exploitation or misappropriation-Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. The policy read in pertinent part, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. II. Altercation between Resident #68 and Resident #71 on 2/14/25 A. Facility investigation The facility investigation was provided by the NHA on 5/21/25 at approximately 3:00 p.m. The investigation documented that on 2/14/25 two residents (Resident #68 and Resident #71) were sitting at the lunch table on the secured unit and experienced an altercation. Resident #71 had spilled a glass of water on the table. According to the investigation, a certified nurse aide (CNA) witnessed Resident #71 take a cup of water and throw it at the Resident #68. The CNA was able to intervene and redirect the residents to prevent further escalation of the incident. The investigation identified the CNA helped Resident #68 changed her shirt and no further incidents occurred. The residents were placed on frequent checks when they were in their rooms and line of sight supervision when they were in common areas in order to prevent additional occurrences. According to the investigation, the incident was substantiated as it did occur. According to the investigation, the incident did not cause psychosocial stress to either resident and interventions were successful for preventing additional incidents. The investigation documented Resident #68 and Resident #71 were interviewed after the incident and neither resident recalled the incident and said they felt safe. The residents returned to their normal daily life and had positive interactions while being monitored in line of sight. B. Resident #68 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident status Resident #68, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included unspecified dementia with moderate agitation, Alzheimer's disease with late onset and anxiety disorder due to known physiological conditions. The 5/9/25 minimum data set (MDS) assessment identified Resident #68 had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. Resident #68 did not use a mobility device but required some staff assistance with activities of daily living (ADLs). According to the MDS assessment, Resident #68 had inattention and disorganized thinking. The resident did not have physical or verbal behavioral symptoms directed towards others. 2. Record review The behavior care plan care plan, revised 6/4/24, identified Resident #68 had a history of cursing at others and hitting and shoving others. Interventions included administering medications as ordered and monitoring and documenting for side effects and effectiveness (initiated 5/8/24), allowing time for the resident to express herself and her feelings towards the situation and assessing her understanding of the situation (initiated 5/8/24) and giving the resident as many choices as possible about her care and activities (initiated 5/8/24). According to the behavior care plan interventions, revised 10/2/24, Resident #68 could be redirected with walking outside, reminiscing, conservations about horses, providing changes in her environment, humor, decreased stimulation, validation and asking her to play her piano. The behavior care plan, revised 2/26/25, identified at times Resident #68 would curse and hit staff. According to the care plan interventions, initiated 2/28/25, staff was to attempt non-pharmological approaches to redirect her behavior to include showing the resident the patio and calling her family. The wandering and elopement risk care plan, revised 12/4/24, identified Resident #68 had impaired safety awareness and her safety should be maintained. Interventions included frequent monitoring checks (initiated 10/25/23). -Review of Resident #68's care plan did not indicate Resident #68 was at risk for abuse or had been a victim of physical abuse. The 2/14/25 situation background assessment and recommendation (SBAR) summary documented Resident #68 had a partial cup of water thrown on her by another resident and was assisted into dry clothes. She had no recollection of the incident and displayed no signs of apprehension or fear. Progress notes on 2/15/25 through 2/20/25 identified that Resident #68 was monitored following the incident with Resident #71. C. Resident #71 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included Alzheimer's disease with late onset, dementia and other diseases elsewhere classified, unspecified severity with agitation and anxiety, cognitive communication deficit, major depression disorder, recurrent with severe psychotic features, mood disturbance and anxiety. The 3/12/25 MDS assessment identified Resident #71 had severe cognitive impairments with a BIMS score of three out of 15. Resident #71 did not use a mobility device but required some staff assistance with her ADLs. According to the MDS assessment, Resident #71 had inattention, disorganized thinking and delusions. The resident had physical behavioral symptoms directed towards others. 2. Record review The physical aggression care plan, revised 1/23/24, identified Resident #71 had a history of physical aggression. Interventions included providing the resident as many choices as possible about her care and activities (initiated 12/29/23), intervening when the resident was agitated, before she escalated with calmly engaging her in conversation (initiated 12/29/23) and if the resident continued to escalate, staff should calmly walk away from her, keep her safe, approach her later and monitor/document/report any signs of danger to herself and others (initiated 12/29/23). The care plan intervention, revised 12/4/24, identified the resident could be redirected with a stuffed bunny, realistic baby dolls, adult coloring books, reminiscing about growing up on the farm, selling corn and raising kids, calling family, being outside, validating her feelings, offering music, such as Elvis and music based activities, one-to-one visiting and deep breathing with mediation. The behavior care plan care plan, initiated 12/7/23 and revised 3/25/25, identified Resident #71 had a history of yelling and cursing at others. Interventions included assessing and anticipating her needs for food, thirst, toileting, comfort level, body positioning and pain (revised 12/4/24), allowing time for the resident to express herself and her feelings towards the situation and assessing her understanding of the situation (initiated 12/7/23) and giving her as many choices as possible about her care and activities. The care plan interventions, revised 7/9/24, identified the resident could be redirected with activity groups, [NAME] pigs and changes in the environment. The 2/14/25 SBAR summary documented Resident #71 threw water from a partially filled cup onto another resident without provocation. According to the note, the resident remained chronically delirious with visual and auditory hallucinations. The 2/16/25 eMAR (electronic medication administration record) general note identified Resident #71 was very anxious. The note documented she attempted to pull a cable and refused to let go when asked. According to the note, the resident became physically and verbally aggressive. The resident was provided a doll and a PRN (as needed) Ativan (anti-anxiety) medication. The progress note did not identify who the resident was physically and verbally aggressive towards. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/18/25 health status note documented Resident #71 continued to be monitored for being a physical aggressor towards another resident (on 2/14/25). According to the note, she was verbally aggressive towards staff. The note indicated Resident #71 was being kept within staff's sight to prevent any verbal or physical aggression. III. Incident of physical abuse of Resident #68 by Resident #65 on 4/6/25 A. Facility investigation The facility investigation was provided by the NHA on 5/21/25 at approximately 3:00 p.m. The investigation identified that on 4/6/25 the clinical nurse on-call was notified that a female resident on the secured unit entered another female resident's room. The investigation documented Resident #65 kicked the other female resident (Resident #68) in the leg/foot. According to the investigation report, Resident #65 was wandering when she entered Resident #68's room. The staff attempted to redirect and intervene but Resident #65 became upset and began kicking at Resident #68 when she was asked to leave the room. The staff removed Resident #65 from Resident #68's room. According to the investigation, Resident #68 was not injured and did not report pain. The investigation indicated neither resident recalled the incident and returned to their normal daily routines. Resident #65 was placed on line of sight in order to prevent additional incidents. The facility investigation identified the incident was witnessed by the CNA. The CNA witness statement identified the CNA heard yelling coming from a resident's room and witnessed Resident #65 kicking Resident #68. The CNA removed Resident #65 from Resident #68's room to separate the residents. According to the facility investigation, neither resident could recall the incident and both residents felt safe. The facility documented the incident was substantiated because physical contact was witnessed. The interventions documented in the facility investigation identified Resident #65 was placed in line of sight in order to prevent a recurrence and medications were reviewed and orders were changed by the physician. Resident #68 was checked in on by the social services assistant and monitored by staff to ensure she exhibited no psychosocial distress. According to the facility investigation, the interventions had been successful as there had not been further incidents. B. Resident #68 (victim) 1. Record review The 4/6/25 SBAR summary documented a resident (Resident #65) entered Resident #68's room. Resident #68 asked Resident #65 to leave which upset Resident #65. Resident #65 kicked Resident #68 in the right lower extremity (RLE). According to the summary, there was no injury, the residents were separated and were back to their baseline behaviors. The 4/8/25 nursing progress note documented Resident #68 was monitored for a resident-to-resident altercation where she was the recipient of being kicked on the RLE. According to the note, the RLE was clear of any injury and no bruising was noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Resident #65 (assailant) 1. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included Alzheimer's disease with late onset, unspecified dementia, unspecified severity with anxiety and other behavioral disturbances and wandering in diseases classified elsewhere. The 3/18/25 MDS assessment identified Resident #65 had severe cognitive impairments with a staff assessment for mental status. The resident required partial to moderate staff assistance with her most ADLs. According to the MDS assessment, Resident #65 had inattention, disorganized thinking and delusions. The resident had verbal behavioral symptoms directed towards others. The MDS identified her behaviors had worsened. 2. Record review The behavior care plan, initiated 7/17/24, identified Resident #65 was intrusive with her peers. According to the care plan, the resident went into other residents' rooms, rifled through their things and took items that did not belong to her. The care planned interventions, initiated (7/17/24), included encouraging the resident to participate in activities of her choice and to utilize the courtyard in appropriate weather, continuing to identify purposeful activities to keep her happy, fulfilled and busy, redirecting her from other residents, their rooms and their possessions while reminding the resident to respect the space of other residents. According to the care plan, the resident liked to go on walks and directed staff to offer their hand to go on a walk. The behavior care plan, initiated 8/14/24 and revised 3/2/25, identified Resident #65 had a history of physical and verbal aggression. The care plan interventions, revised 9/4/24, included giving the resident as many choices about care as possible, intervening when the resident was agitated before she escalated, redirecting her to calm one-to-one conversations, walks outside and music and dancing. According to the care plan, if the resident continued to escalate, staff should walk away, keep her safe and reapproach later. The behavior care plan, revised 2/10/25, identified Resident #28 could become tearful and voice sadness. The intervention, initiated 3/12/25, directed staff to monitor her more closely when she was not in the commons area. -The care plan did not identify new interventions after Resident #65 entered Resident #68's room and kicked her when Resident #68 asked her to leave. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/6/25 nursing progress note documented a CNA heard Resident #65 upset, with her voice raised, in the room of Resident #68. The CNA entered Resident #68's room and saw Resident #65 kicking Resident #68 in the right lower extremity. According to the note, Resident #65 was cursing with a raised voice as she held a baby doll. The CNA assisted Resident #65 out of the room of Resident #68 and attempted to calm her down with a walk outside. The note documented Resident #65 was assessed and the resident's foot did not identify visible marks or discolorations. The note did not identify if Resident #68 was assessed for injury. The note indicated Resident #65 would be monitored every 15 minutes for 72 hours. The 4/7/25 health status note documented staff continued to conduct 15-minute checks on Resident #65. According to the note, Resident #65 was in and out of other residents' rooms, in the kitchen and in the dining room without resident-to-resident altercations and close monitoring would continue. The 4/8/25 nursing progress note documented Resident #65 continued to go in and out of residents' rooms without resident-to-resident aggressive interactions. The 4/10/25 nursing progress note documented Resident #65 continued to pace up and down the hallway and outside and go in and out of other residents' rooms. According to the note, the resident was easily redirected. IV. Incident of physical abuse directed toward Resident #71 by Resident #68 on 5/18/25 A. Facility investigation The facility investigation was provided by the NHA on 5/22/25 at approximately 11:00 a.m. The investigation identified a physical altercation on 5/18/25 was witnessed by a registered nurse (RN) and a CNA on the secured unit. The RN witness statement documented she witnessed Resident #71 telling people off. According to the witness statement, Resident #71 and Resident #68 were in the dining room together and Resident #71 was being verbal towards Resident #68. Resident #68 started to walk away from Resident #71 when Resident #71 called her a foul name. Resident #68 then slapped Resident #71. The investigation documented the residents were separated, there were no injuries to either resident and neither resident could recall the incident. The CNA witness statement documented Resident #68 entered the dining room and Resident #71 started saying things to Resident #68. According to the witness statement, the CNA attempted to redirect Resident #68 out of the dining room when Resident #71 called Resident #68 a derogatory name. The witness statement identified Resident #68 turned around and slapped Resident #71. B. Resident #71(victim) 1. Record review The 5/18/25 at 2:49 p.m. nursing progress note documented Resident #71 and Resident #68 were standing in the dining area exchanging unpleasant words. Resident #68 started to walk away when Resident #71 called Resident #68 a bad name. The note documented Resident #68 turned around and slapped Resident #71 on the left side of her face. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/19/25 at 2:09 p.m. health status note documented Resident #71 was observed to be restless on the evening of 5/19/25. According to the note, Resident #71 was monitored for being a physical aggression recipient and was followed around by staff to prevent further physical aggression. C. Resident #68 (assailant) 1. Record review The 5/21/25 health status note documented Resident #68 was being monitored for initiating physical violence towards another resident (Resident #71). According to note, there had been no further episodes of physical aggression and Resident #68 had been friendly to other residents and staff. V. Staff interviews The director of nursing (DON) was interviewed on 5/21/25 at 3:26 p.m. The DON said to prevent resident-to-resident altercations the facility had been working on identifying staff that worked well with the memory care population, incorporating interventions and offering individualized activities and snacks. She said staff should look for cues of agitation and redirect the residents by taking them on a walk and changing their location if needed. The DON said if an incident occurred, staff should separate the residents, provide 15- minute checks for 72 hours or longer if needed, keep the residents in line of sight and provide ongoing checks on the residents, as needed, if determined in the care plan. The DON said Resident #68 had a history of altercations with residents. She said the resident could get easily frustrated and agitated with other residents and could increase other residents' agitation. She said pain and fatigue could contribute to her agitation. She said staff addressed her pain as needed. The social services assistant (SSA) was interviewed on 5/21/25 at 4:08 p.m. The SSA said she conducted the facility abuse investigations and the NHA determined if abuse was substantiated. She said she collected the data, interviewed staff and residents involved to identify what happened and checked if other residents were impacted and if everyone felt safe. She said the interdisciplinary team (IDT) would try to find the root cause and look at interventions to help prevent the incidents from happening again. She said staff would be verbally educated if needed. The SSA said Resident #71 and Resident #68 did not recall past altercations with each other and desired to be around each other. She said staff should keep both residents in their line of sight and observe their interactions with each other. The activities director (AD) was interviewed on 5/22/25 at 3:01 p.m. The AD said the facility recently had dementia training and she started a new activity program on the secured unit to help provide more meaningful and purposeful activities that offered more rummaging, sensory and past lifestyle chore- like activities. She said she had seen an improvement in residents' engagement and behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The infection preventionist (IP) and the corporate consultant (CC) were interviewed together on 5/22/25 at 4:34 p.m. The IP identified herself as the secured unit manager. She said her role in helping prevent abuse and resident-to-resident altercations was to support her staff and provide them with an extra set of eyes on the residents. The IP said she tried to go into the secured unit daily, depending on how much else she had going on throughout the day. The IP said if Resident #71 was agitated, staff should redirect the resident with a walk outside or an activity to change her focus and try to keep her away from Resident #68. She said staff should try to keep Resident #68 away from Resident #71 when they were able to and offer activities that she liked. The IP said Resident #65 went into other residents' rooms. She said staff should redirect Resident #65 from going into a resident's room if she had prior issues with that particular resident. The IP said she had tried putting stop sign banners across the residents' doors but the residents would tear them down. The IP said it was staff's goal to minimize resident-to-resident incidents so staff tried to keep eyes on everyone. She said all residents were kept in line of sight. She said anytime there was a new incident, staff would look at incorporating new interventions and determine what interventions were working and what interventions were not. The CC said the facility had an increase in resident-to-resident altercations so they brought in a certified dementia trainer to provide additional dementia education. She said the training was in March 2025 and in April 2025 so all the staff could receive the training. The IP said she was not available for the dementia training that was offered but the training was available online. The CC said the facility was going to continue to try to revamp the activity program, continue to train staff and rotate staff that did well working with residents with dementia. The NHA was interviewed on 5/22/25 at 5:18 p.m. The NHA identified the above incidents all occurred during the day between lunch time and 2:45 p.m. He said Resident #71 was a resident that staff worked with everyday and with her family to try to meet her needs and de-escalate her behaviors. He said staff continued to try to prevent resident-to-resident altercations but could not prevent them all. The NHA said the facility would continue to provide specialized dementia training and continue to focus on activities that engaged the residents to help mitigate behaviors. He said the facility had not identified a trend/pattern in the resident-to-resident altercations. The NHA said the facility would continue to offer residents and staff support and offer education.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** VI. Resident #387 A. Resident status Resident #387, age over 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included stage three chronic kidney disease and bipolar disorder. The 7/4/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required partial to moderate assistance with toileting, personal hygiene, bathing and lower body dressing. B. Record review A review of Resident #387's May 2025 CPO revealed the following physician's orders: Olanzapine (Zyprexa, an antipsychotic medication) oral tablet 5 mg, give 2.5 mg (half tablet) by mouth as needed (PRN) for agitation daily at night, ordered 5/17/25 with an end date of 5/31/25. Lorazepam (an antianxiety medication) oral tablet 0.5 mg, give one tablet by mouth daily PRN for anxiety, ordered 5//25 with an end date of 5/31/25. Lamotrigine oral tablet give 50 mg by mouth one time a day related to bipolar disorder, ordered 5/18/25. Monitor resident's behaviors, such as rapid mood changes and paranoia while prescribed Zyprexa related to bipolar disorder. Interventions included calling the resident's son and changing the resident's environment, ordered 5/17/25. Monitor resident's behaviors, such as voicing depression and negative comments while prescribed Lamotrigine related to bipolar disorder. Interventions included one-on-one interactions and group activities, ordered 5/17/25. Monitor residents behavior, such as voicing being worried and perseveration while prescribed Lorazepam for anxiety. Interventions included decreased stimulation and providing reassurance, ordered 5/19/25. Review of the May 2025 MAR, from 5/17/25 to 5/21/25, revealed Resident #387 was not administered the PRN Zyprexa or PRN Ativan. -A review of Resident #387's May 2025 MAR and treatment administration record (TAR) revealed the physician's orders for behavior monitoring were not transcribed onto the TAR and there was no place on the TAR for staff to document if the resident was exhibiting behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the progress notes did not reveal documentation to indicate Resident #387 had exhibited episodes of anxiety, rapid mood changes or paranoia prior to the physician prescribing PRN Zyprexa and PRN Ativan for the resident. -Additionally, Resident #387's EMR did not reveal documentation from the physician which provided a diagnosed specific condition and indication for use of the medication in order to justify starting the resident's PRN antipsychotic and PRN antianxiety medications. C. Staff interviews CNA #11 was interviewed on 5/22/25 at 3:54 p.m. CNA #11 said Resident #387 had been pleasant since her admission to the facility. CNA #11 said Resident #387 had not displayed any aggressive behaviors. Registered nurse (RN) #1 was interviewed on 5/22/25 at 3:56 p.m. RN #1 said staff were monitoring Resident #387 for repetitive delusions. RN #1 said he had not seen Resident #387 display any delusional behaviors. RN #1 said Resident #387 was prescribed lorazepam for anxiety and olanzapine at bedtime for agitation as needed. He said Resident #387 had not been given olanzapine since the medication had been prescribed because Resident #387 had not displayed any aggressive behaviors. RN #1 said the resident's EMR did not have a place to record the resident's behaviors if they were exhibited. RN #1 said Resident #387 had not displayed any agitated behaviors since her arrival to the facility. RN #1 said the olanzapine was ordered to manage Resident #387's agitation. RN #1 said the physician saw Resident #387 on 5/22/25 and did not make any changes to her medications. The DON and the CC were interviewed on 5/22/25 at 5:06 p.m. The DON said she did not think Resident #387 had displayed any kind of aggressive or anxious behaviors since her admission to the facility. The DON said she was not sure if Resident #387 needed to be prescribed olanzapine and lorazepam. The DON said the medication was prescribed for fourteen days and would more than likely be discontinued on 5/31/25. -However, there was no documented rationale to justify the medications being prescribed initially (see record review above). V. Resident #5 A. Resident status Resident #5, age [AGE], was admitted on [DATE]. According to the May 2025 CPO, diagnoses included dementia in other diseases classified elsewhere, severe with psychotic disturbance, Parkinsonism (a condition that causes tremors, stiffness and slowed movement) and need for assistance with personal care. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2/26/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. She required staff assistance for most activities of daily living (ADL), including setup assistance with eating and personal hygiene and moderate assistance with dressing, bathing, and toileting. The MDS assessment revealed the resident did not display physical behaviors directed towards others and did not exhibit any verbal or behavioral outbursts during the assessment period. B. Record review A review of Resident #5's May 2025 CPO revealed the following physician's order: -Olanzapine, give 7.5 mg by mouth at bedtime for dementia with psychosis, ordered 11/18/24. -Review of Resident #5's MARs, from 11/1/24 to 5/20/25, did not reveal documentation of a targeted behavior or any behavior monitoring for the use of the resident's olanzapine medication. A review of the nursing progress notes, from 1/1/25 to 5/20/25, revealed the resident exhibited only one episode of verbal aggression and paranoid delusions on 4/30/25. -Despite Resident #5's EMR revealing no documentation of outbursts or physical behaviors to justify the continued use of the resident's antipsychotic medication, the facility continued administering olanzapine, citing poor interaction with her children as the rationale. The 2/24/25 monthly MRR indicated that the resident's olanzapine 7.5 mg dose exceeded the recommended maximum for dementia with psychosis. The pharmacist recommended reducing the dose to 5 mg, in accordance with standards of practice and gradual dose reduction (GDR) requirements. The physician declined the recommendation, citing a recent poor interaction between the resident and her children. -However, review of progress notes, behavior tracking logs, and psychotropic medication notes did not reveal documentation of ongoing targeted behaviors for Resident #5 or any incidents of verbal aggression or paranoid delusions in order to justify the continued use of the higher dose of the medication. C. Staff interviews The consultant pharmacist was interviewed on 5/22/25 at 11:08 a.m. The consultant pharmacist said it was not typical to continue a high dose of an antipsychotic medication based on a single behavioral incident. The consultant pharmacist said the dose prescribed for Resident #5 exceeded the maximum recommended dosage of olanzapine and she recommended a reduction of the medication for the resident. She said she was not aware Resident #5 had exhibited any behaviors to continue the medication at such a high dose. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified nurse aide (CNA) #8 was interviewed on 5/22/25 at 2:20 p.m. CNA #8 said Resident #5 had not exhibited any verbal or physical aggression, yelling, hitting, or wandering. CNA #8 said the resident sometimes became anxious due to sun downing but was redirectable to activities, such as playing bingo or visiting with other residents. CNA #8 said the resident had not had any outbursts or done anything that put herself or others at risk. CNA #8 said when Resident #5 seemed upset or anxious, the staff redirected her and allowed the resident to talk because letting her express herself helped calm her down. CNA #11 was interviewed on 5/22/25 at 2:43 p.m. CNA #11 said Resident #5 sometimes mentioned that her roommate should pay rent, but staff redirected her by reassuring her that the roommate was paying rent and there were no further issues. CNA #11 said the resident had not exhibited any verbal or physical aggression. CNA #11 said the resident did not usually appear anxious and had not had any outbursts. The DON was interviewed on 5/22/25 at 4:20 p.m. The DON said both the physician and nursing leadership reviewed the pharmacist's recommendations monthly. The DON said the facility monitored all residents on antipsychotic medications, including those with dementia, through behavior tracking, which was documented on the MAR and quarterly psychotropic medication reviews by the leadership team. The DON said a thorough risk versus benefit assessment and statement should have been completed for Resident #5's use of olanzapine. She said targeted behavior monitoring was required for all psychotropic medications and should have been documented in the MAR for Resident #5's use of olanzapine. She said the current dosage of olanzapine medication for Resident #5 exceeded the therapeutic range.Based on record review and interviews, the facility failed to ensure four (#48, #61, #5 and #387) of seven residents reviewed for psychotropic medications were free from chemical restraint out of 37 sample residents. Specifically, the facility failed to: -Ensure a physicians rationale, which included the diagnosed specific condition and indication for use of the medication, was documented for the use of an as needed (PRN) antianxiety medication beyond 14 days for Resident #48; -Ensure Resident #48 was not administered a PRN psychotropic medication prescribed for anxiety without appropriate behavior documentation; -Ensure a physicians rationale, which included the diagnosed specific condition and indication for use of the medication, was documented for the use of a PRN antianxiety medication for Resident #61; -Document consistent behaviors or a physician's rationale for Resident #5 to justify the continued use of an antipsychotic medication; and, -Ensure a physicians rationale, which included the diagnosed specific condition and indication for use, was documented for the use of an antipsychotic medication and an antianxiety medication for Resident #387. Findings include: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Facility policy and procedure The Psychotropic Medication Use policy and procedure, revised July 2022, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. It revealed in pertinent part, Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are not antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team (IDT) conducts an evaluation of the resident. The evaluation will attempt to clarify whether or not the resident has signs and symptoms that are clinically significant enough to warrant medication therapy. II. Resident #48 A. Resident status Resident #48, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), emotional lability and depression. The 3/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was dependent on staff for bathing and required moderate assistance with personal hygiene and toileting. The MDS assessment revealed the resident had moderately severe depression symptoms with no aggressive behavior observed toward herself or others. B. Resident interview Resident #48 was interviewed on 5/20/25 at 2:30 p.m. Resident #48 said when she was admitted to the facility she was on hospice services, but a few weeks ago she was told she was doing well and discharged from hospice services. Resident #48 said she did not have any anxiety. C. Record review A review of Resident #48's physician order history revealed the following physicians orders: Diazepam two milligrams (mg) oral tablet. Give one tablet by mouth three times a day as needed for anxiety related to emotional lability, ordered 3/19/25 with an end date of 4/8/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diazepam two mg oral tablet. Give one tablet by mouth every eight hours as needed for anxiety related to emotional lability for 90 Days, ordered 4/8/25 with an end date of 7/7/25. The monthly pharmacy medication regimen review (MRR), dated 3/26/25, documented the consultant pharmacist sent a recommendation to the prescribing physician to reassess the use of the PRN diazepam. The prescribing physician's response, dated 4/7/25, documented the physician disagreed with the recommendation with the word hospice hand written as the rationale to continue the PRN order for 90 days. -Review of Resident #48's electronic medical record (EMR) revealed there was no further documentation from the physician which provided a diagnosed specific condition and indication for use of the medication in order to justify extending the residents PRN diazepam beyond 14 days. A review of Resident #48's medication administration records (MAR), from 4/8/25 through 5/21/25 revealed the resident received one PRN dose of diazepam during that time period, on 4/14/25 at 4:55 a.m. A review of the April 2025 treatment administration record (TAR) revealed Resident #48 did not have any documented episodes of anxiety since the orders initial start date, including on the 4/14/25, when the medication was administered. The April 2025 MAR additionally revealed that Resident #48 received a PRN dose of oxycodone 2.5 mg for pain at the same time the diazepam was administered on 4/14/25 at 4:55 a.m. The progress note, dated 4/14/25, documented Resident #48 had a difficult night due to severe low back pain. Resident #48's pain was initially treated with acetaminophen without relief. Resident #48 subsequently received PRN oxycodone and diazepam with good effect. Resident #48 was able to sleep in the recliner afterward. -However the physician's order for PRN diazepam indicated the medication was prescribed for a diagnosis of anxiety and there was no documentation in the residents EMR to indicate the resident was exhibiting or reporting anxiety at the time the medication was administered. The nursing progress note, dated 5/12/25, documented Resident #48 was discontinued from hospice services. -However, there were no changes made to Resident #48's PRN physicians order for diazepam or a new rationale documented by the physician, despite hospice services being the only rationale documented for extending the physicians order past 14 days. III Resident # 61 A. Resident status Resident #61, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included vascular dementia without behavioral disturbance, amyloidosis and repeated falls. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/26/25 MDS assessment revealed that the resident had severe cognitive impairment with a BIMS score of five out of 15. The resident required substantial assistance with bathing, and moderate assistance with toileting, transfers, hygiene and dressing. The MDS assessment revealed the resident did not have anxiety, depression or aggressive behavior toward himself or others. B. Record review A review of Resident #61's March 2025 CPO revealed the following physician's order upon Resident #61's admission to the facility: Lorazepam 0.5 mg tablet, give 0.5 mg by mouth every four hours as needed for anxiety or shortness of breath, ordered 3/13/25 with an end date of 4/8/25. A review of the March 2025 and April 2025 MAR revealed Resident #61 received no doses of PRN lorazepam from 3/13/25 through 4/8/25. A review of the March 2025 and April 2025 TAR documented Resident #61 had no observations of anxiety from 3/13/25 through 4/8/25. The nursing progress note, dated 3/18/25 at 12:52 p.m., documented the facility reviewed Resident #61's current use of psychotropic medications. It documented Resident #61's family denied a significant history of anxiety or depression for Resident #61. The family said he had been doing very well and they did not have any concerns. -Additionally, there was no documentation in the nursing progress notes to indicate the resident was having anxiety from 3/13/25 through 4/8/25. The monthly pharmacy MRR, dated 3/26/25, documented the consultant pharmacist sent a recommendation to the prescribing physician to reassess the use of the Resident #61's PRN lorazepam. The prescribing physician's response, dated 4/7/25, documented the physician disagreed with the recommendation with the word palliative hand written in the rationale and to continue the PRN order for 90 days. -Review of Resident #61's EMR revealed there was no further documentation from the physician which provided a diagnosed specific condition and indication for use of the medication in order to justify extending the residents PRN lorazepam beyond 14 days. A review of Resident #61's May 2025 CPO revealed the following physicians order: Lorazepam 0.5 mg tablet, give 0.5 mg by mouth every four hours as needed for anxiety or shortness of breath for 90 days, ordered 4/8/25 with an end date of 7/7/25. A review of Resident #61's April 2025 and May 2025 MAR revealed Resident #61 was not administered any doses of the PRN Lorazepam from 4/8/25 through 5/21/25. The April 2025 and May 2025 TAR revealed Resident #61 had no observations of anxiety from 4/8/25 through 5/21/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note, dated 5/12/25, documented Resident #61 expressed feeling anxious during a mental health screening. -However no further interventions were documented, no PRN use of the ordered lorazepam was documented and there was no documentation of anxiety in the behavior tracking on the May 2025 TAR for 5/12/25. IV. Staff interviews The consultant pharmacist was interviewed on 5/22/25 at 10:44 a.m. The consultant pharmacist said diazepam could be used for spastic pain (muscle spasms), but otherwise she would not recommend the use of diazepam for back pain. The consultant pharmacist said giving both medications (diazepam and oxycodone) together could increase the risk for sedation and death. The consultant pharmacist said she sent notifications, for both the PRN diazepam for Resident #48 and the PRN lorazepam for Resident #61, to the physician when she completed the March 2025 monthly MRRs. She said the physician disagreed with her recommendation to discontinue both medications. She said both medications were not necessary because both residents were not exhibiting signs or symptoms of anxiety and there was non-use of the medications. The director of nursing (DON) and the corporate consultant (CC) were interviewed together on 5/22/25 at 4:01 p.m. The DON said PRN antianxiety medications should be written with a 14-day stop date. She said after the 14 days ended, the physician was required to evaluate the appropriateness of the medication and provide a new prescription with a new stop date. The DON said the evaluation should include an appropriate risk versus benefit assessment and evidence that other interventions were not effective. The DON said PRN antianxiety medications should be discontinued due to a lack of effectiveness of the medication or non-use. She said the PRN antianxiety orders for both Resident #48 and #61 should be discontinued if both residents did not display signs and symptoms of anxiety. The DON said diazepam and oxycodone should not be administered together for documented back pain without the resident indicating they were also experiencing anxiety.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#80) of two residents with limited range of motion out of 37 sample residents received appropriate treatment and services. Specifically, the facility failed to ensure Resident #80 was consistently provided services through the walk-to-dine program in order to maintain the resident's ambulation status. Findings include: I. Facility policy and procedure The Restorative Nursing Services policy, revised July 2017 was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. It revealed in pertinent part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (physical, occupational or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. The resident or representative will be included in determining goals and the plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: adjusting or adapting to changing abilities; developing, maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence and self-esteem; and participating in the development and implementation of his/her plan of care. II. Resident #80 A. Resident status Resident #80, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included functional quadriplegia (immobility related to weakness without injury to the brain or spinal cord), history of falls, altered mental status and fibromyalgia (chronic widespread body pain and fatigue). The 3/19/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident was dependent on staff for bathing and required moderate to substantial assistance with dressing, footwear and hygiene. The resident required moderate assistance with repositioning in a chair or bed as well as transferring (moving from lying to sitting, sitting to standing or from bed to chair). (continued on next page)

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	065253	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Villa Grande Care Center	2501 Little Bookcliff Dr Grand Junction, CO 81501

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview and observations On 5/19/25 at 10:35 a.m. Resident #80 was being assisted by an unidentified staff member transferring from the bed to her wheelchair. The unidentified staff member wheeled Resident #80 to the morning group activity. On 5/19/25 at 12:08 p.m. Resident #80 was wheeled in her wheelchair by an unidentified staff member from her room to the dining room. -The unidentified staff member did not offer to ambulate Resident #80 to the dining room. Resident #80 was interviewed on 5/19/25 at 4:21 p.m. Resident #80 said she thought the physical therapist put her on a program to walk to the dining room. She said she could only recall one time in the last two weeks that a staff member assisted her with ambulating to the dining room. Resident #80 said there was a green card on the back of her wheelchair that identified she was on the walk-to-dine program; however, staff did not offer to provide her with ambulation to the dining room. She said she was concerned with not being able to maintain her ambulation without the walk-to-dine program being provided. During the interview, Resident #80's wheelchair was observed with a green symbol of a walking man on the back handle of her wheelchair. On 5/20/25 at 11:47 a.m. Resident #80 was assisted by an unidentified staff member from her room to the dining room via her wheelchair. -The unidentified staff member did not offer to ambulate Resident #80 to the dining room. C. Record review The 3/25/25 progress note revealed Resident #80's representative requested a physical therapy (PT) referral for Resident #80. The 5/13/25 PT discharge summary revealed Resident #80 received physical therapy services from 4/2/25 to 5/13/25. The physical therapy discharge summary documented Resident #80 required the use of a four-wheeled walker with supervision or touching assistance to ambulate. The Kardex (a tool utilized by staff to provide consistent resident care)for Resident #80 was provided by the NHA on 5/22/25 at 6:00 p.m. It revealed instructions to the facility staff to offer Resident #80 assistance to ambulate to and from the dining room for every meal. -Review of Resident #80's activities of daily living (ADL) care plan, initiated 1/30/25, revealed the care plan was not updated to include ambulating the resident to the dining room for meals. III. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #3 was interviewed on 5/22/25 at 1:18 p.m. CNA #3 said the green walking man symbol on residents' doorways and attached to different residents' assistive devices indicated a resident was on the walk-to-dine program. She said she thought Resident #80 was on the walk-to-dine program, but she said was not sure. Registered nurse (RN) #1 was interviewed on 5/22/25 at 12:08 p.m. RN #1 said he thought the green walking man symbol meant physical therapy approved the resident for weight-bearing status. RN #1 said he was not sure how physical therapy communicated to staff which residents were on the walk-to-dine program since usually the CNAs assisted residents to the dining room. The director of rehabilitation (DOR) was interviewed on 5/22/25 at 2:41 p.m. The DOR said the green walking man was the symbol to alert facility staff that the resident was part of the walk-to- dine program. The DOR said the walk-to-dine program meant staff assisted residents with ambulation to the dining room. She said staff were to maintain contact with the resident using a gait belt and a wheelchair following the resident, in case the resident needed to sit down. The DOR said the goal of the walk-to-dine program was to maintain the physical abilities of residents in the facility. The DOR said the physical therapist was responsible for providing the nursing staff with education of each particular resident that was placed on the walk-to-dine program. The DOR said Resident #80 was discharged from PT on 5/13/25. The DOR said the discharge summary did not specify Resident #80 was placed on the walk-to-dine program, however, she said the summary did recommend supervision with contact assistance to ambulate up to 75 feet with a four-wheeled walker, which described the walk-to-dine program. The DOR said she could not find any other communication in the resident's electronic medical record (EMR) to confirm the staff were informed whether or not Resident #80 was on the walk-to-dine program starting on 5/13/25. The director of nursing (DON) and the corporate consultant (CC) were interviewed on 5/22/25 at 4:01 p.m. The DON said she could not recall if Resident #80 was on the walk-to-dine program, but she said the green walking man symbol indicated that the resident was part of the program. The DON said the goal of the walk-to-dine program was to help residents maintain mobility. The DON said the walk-to-dine program was initiated by the PT and the minimum data set coordinator (MDSC). The DON said the resident's care plan and Kardex should be updated upon initiation of the program.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#28) of three residents out of 37 sample residents. Resident #28, who was at risk for falls, was admitted on [DATE] with diagnoses of dementia, history of falling, abnormalities of gait and mobility, weakness and insomnia. On 5/1/25 the physician recommended the resident transition to a walker without wheels for safety and have a physical therapy (PT) evaluation. However, Resident #28 continued to use her four-wheel walker and a PT evaluation was not conducted until 5/13/25. Resident #28 fell three times in less than a week (on 5/6/25, 5/9/25 and 5/10/25). She was identified to have high blood pressure after the falls and was discovered to have a urinary tract infection (UTI) after the last fall on 5/10/25, increasing her risk for falls. All three of the falls occurred in the early morning hours when Resident #28 got out of bed independently. However, the facility failed to identify a pattern with the falls. Two of the three falls resulted in injuries, including facial injuries. The 5/10/25 fall resulted in the resident going to the hospital for stitches to her head. Specifically, the facility failed to identify and implement timely interventions for Resident #28 to help decrease her risk for patterned falls and risk of falls with injury. Findings include: I. Facility policy and procedure The Falls-Clinical Protocol policy, revised September 2012, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. The policy read in pertinent part, For an individual who has fallen, staff will attempt to find possible causes within 24 hours of the fall. Causes refer to factors that are associated with or that directly result in the fall. Often multiple factors in varying degrees contribute to a fall problem. The staff and the physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Frail elderly individuals are often at a greater risk for serious adverse consequences of the fall. Risk of serious adverse consequences can sometimes be minimized if falls can not be prevented. If interventions have been successful in preventing falls, the staff will continue the current approaches or reconsider whether the measures are still needed if the problem that required the intervention has been resolved. If the individual continues to fall, the staff and the physician will reevaluate the situation and consider other possible reasons for the resident falling and will reevaluate the continued relevance of current interventions. II. Resident #28 A. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #28, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, unspecified dementia, without behavioral disturbance, history of falling, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (stoke), other abnormalities of gait and mobility, weakness and insomnia. The 2/8/25 minimum data set (MDS) assessment documented Resident #28 had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. According to the MDS assessment, Resident #28 needed partial to moderate assistance with dressing, including putting on and taking off footwear, toileting and personal hygiene. She needed touching or supervision with a sit to stand position. She used a walker for mobility. B. Resident observation and interview On 5/19/25 Resident #28 was observed throughout the day in the memory care unit. The resident had red, purple and green bruising on her face. The bruising was primarily under her left eye, on her left cheek and on her forehead. Resident #28 used a four-wheel walker for ambulation. Resident #28 was interviewed on 5/19/25 at 2:45 p.m. Resident #28 said she did not know what happened to cause the bruising on her face but she was happy the bruises were getting better. C. Record review The fall care plan, initiated 8/2/24 and revised 5/6/25, identified Resident #28 was at risk for falls. Interventions included reminding the resident to use her walker (initiated 8/22/24), ensuring the resident was wearing appropriate footwear and/or non-skid socks when she was ambulating (initiated 8/22/24 and revised 5/6/25), providing a therapy screen as needed (initiated 5/6/25), the resident was participating in a restorative program (initiated 5/7/25), a medication review was conducted with Resident #28's physician (initiated 5/9/25), placing the resident on a toileting schedule (initiated 5/12/25), keeping the resident's bed in the lowest position (initiated 5/11/25 and revised 5/21/25, during the survey), encouraging the resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility (initiated 5/21/25, during the survey) and reviewing information on past falls and attempting to determine the cause of falls, recording possible root causes, altering or removing any potential causes if possible and educating the resident/family/caregivers and the interdisciplinary team (IDT) of the fall causes (initiated 5/21/25, during the survey). The 5/1/25 history and physical physician's note documented Resident #28's blood pressure was 140/82 millimeters of mercury (mmHg). The note identified Resident #28's blood pressure was well-controlled during the visit and the resident would continue on her current medications of amlodipine and lisinopril (high blood pressure/hypertension medications). The physician's note indicated Resident #28 had mobility issues and recommended the resident transition to a walker without wheels for safety, have a PT evaluation and have fall preventive measures in place. -However, the resident continued to use the four-wheel walker (see observations above and progress notes below). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 5/6/25 general progress note documented Resident #28 was found sitting on the floor at 4:45 a.m. She was putting her shoes on and her four-wheeled walker was beside her. Resident #28 was not able to identify if she fell or not but asked if it was time to get up. According to the note, the nurse who observed the resident on the floor felt the resident was possibly trying to get her shoes on while sitting on her four-wheel walker and the walker slid back, causing her to sit on the floor. The note identified the resident did not have skin trauma or shearing and was able to walk from the bed to the toilet without difficulty. The 5/6/25 fall risk data collection evaluation identified Resident #28 scored a 12, indicating she was a fall risk. According to the fall risk data collection evaluation instructions, interventions should promptly be put in place when a resident's score was 10 or more. The change of condition evaluation identified Resident #28 had a blood pressure of 148/76 mmHg on 5/6/25 at 5:12 a.m., indicating a high blood pressure. The 5/7/25 health status note documented Resident #28 was reminded not to sit on her walker for safety, but she was forgetful about the reminder and sat down her walker multiple times without locking her walker brakes. The 5/7/25 IDT at-risk note documented Resident #28's current fall intervention was to ensure she was wearing appropriate footwear and non-skid socks when she was ambulating and to remind her to use her walker. The at-risk note documented occupational therapy (OT) would evaluate and treat the resident for lower body dressing and the resident would participate in the restorative nursing program. The 5/9/25 at 4:45 a.m. nursing progress note documented Resident #28 came out of her room scooting on her buttocks and said she fell. The nursing assessment identified Resident #28 had a bruise forming to her left eye and cheek area and superficial cuts above her eyebrow. The area was cleaned and a bandage was applied. According to the progress note, the resident said she fell and hit her cheek on the floor when she got out of bed. The 5/9/25 at 5:40 a.m. health status note documented Resident #28 was being monitored for a fall on 5/6/25. She complained of left leg discomfort prior to going to bed this shift (5/8/25 into 5/9/25). According to the note, Resident #28 was sleeping in her bed prior to her 5/9/25 fall. The 5/9/25 IDT post-fall investigation documented Resident #28 had an unwitnessed fall at 2:45 a.m. The investigation identified the resident was last checked on by staff at 12:00 a.m. According to the fall investigation, the resident's current fall risk was high. The fall investigation indicated the fall factors included an unsteady gait, getting out of bed and poor lighting. The determining cause of the fall was weakness while ambulating without assistance. The resident was wearing socks at the time of the fall. The investigation indicated the resident was last toileted (on 5/8/25) at 9:00 p.m. The fall investigation documented there was not a noted pattern of falls. -However, the resident previously fell on 5/6/25 in the early morning hours after getting out of bed without assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The note identified Resident #28 was last checked on by staff two hours and 45 minutes before the resident fell and scooted out of her room on her buttocks. The 5/9/25 fall risk data collection evaluation identified Resident #28's fall risk increased from a score of 12 to a 23 after her second fall. The resident's mobility was unsteady with problems and with devices. The 5/9/25 change of condition evaluation identified Resident #28's blood pressure was 182/88 mmHg at the time of the 2:45 a.m. fall, indicating a high blood pressure. According to the evaluation, she was having some discomfort to the left side of her face. The 5/9/25 fall incident report identified Resident #28 was not using her walker and had only regular socks on her feet while attempting to get out of bed to ambulate when she fell. According to the blood pressure log, the resident's blood pressure was trending upward and the medical director would elevate and perform a medication review. The 5/10/25 at 6:05 a.m. nursing progress note documented a certified nurse aide (CNA) was rounding in Resident #28's room and found the resident on the floor, bleeding from her head. According to the note, Resident #28 told the CNA that she fell and hit her head on the floor. The note identified the resident had a round dollar-size area noted to the middle top of her forehead/head, a bruise on her left knee, a bruise and a skin tear to her right knee and a bruise and a skin tear to her right elbow. The injured areas were cleaned and dressed. The 5/10/25 at 8:00 a.m. nursing progress note documented Resident #28 complained of left hip and knee pain and was sent to the hospital for Xrays. The 5/10/25 at 11:00 a.m. nursing progress note identified Resident #28 returned from the hospital with two staples in her forehead. The 5/10/25 post-fall investigation documented Resident #28 fell at 5:25 a.m. when she got out of bed and was walking. The investigation identified the resident was last checked on by staff at 2:00 a.m. The investigation identified she self-toileted herself at times throughout the night and was last known to toilet at 4:00 a.m. The investigation indicated the resident had an increased need for assistance with noted weakness and a positive UA. The new interventions after the 5/10/25 fall included a PT evaluation and placing the resident on a toileting program. According to the post fall investigation, Resident #28 did not have a pattern associated with her falls. -However, each of the falls on 5/6/25, 5/9/25 and 5/10/25 were unwitnessed, occurred on the overnight shift in the early morning hours and happened when the resident got herself out of bed. -Additionally, the physician recommended a PT evaluation on 5/1/25, prior to the three falls on 5/6/25, 5/9/25 and 5/10/25 (see physician's note above). The 5/10/25 incident report documented Resident #28 was ambulating in her room without her walker in the dark room with only a night light on. The 5/10/25 at 5:37 p.m. nursing progress note identified the hospital did not complete the requested Xrays of the resident's left hip and knee and the resident had to return to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 5/10/25 at 10:00 p.m. encounter note identified a nurse requested a physician's order for urine analysis (UA) laboratory (lab) work due to Resident #28's increased confusion and frequency and difficulty with urinating. The 5/11/25 at 4:31 a.m. health status note documented Resident #28 returned from the hospital at 9:35 p. m. (on 5/10/25) with no fractures. A second health status note on 5/11/25 at 4:33 a.m. documented Resident #28 was being monitored for her multiple falls, multiple bruises to her bilateral arms and knees, skin tears to her left knee and right elbow, a laceration with staples to her head and bruising to her face and both eyes. According to the note, Resident #28 complained of pain and discomfort. The note identified the resident continued to be a high fall risk and she almost fell again when she was observed to walk from her bed to the bathroom. The note indicated the nurse conducted multiple checks on the resident and kept her bedroom door open so the resident could be monitored. Resident #28 was dressed with non-skid socks on her feet for safety. The 5/11/25 at 8:45 a.m. electronic medical administration (eMAR) general note identified Resident #28 received oxycodone pain medication for 8 out of 10 pain and was limping. The 5/11/25 at 5:27 p.m. eMAR general note identified Resident #28 received oxycodone pain medication for 9 out of 10 pain to her left leg and face when she got up for dinner. The 5/12/25 physician's progress note identified Resident #28 had a UTI and was prescribed antibiotics. According to the note, the resident would continue to remain on amlodipine and lisinopril for high blood pressure. The 5/12/25 health status note identified Resident #28 was monitored every hour and offered toileting to prevent her from falling. The 5/13/25 health status note documented Resident #28 was administered oxycodone twice due to her complaints of generalized pain. According to the note, the pain medication was only a temporary relief because she complained again when she was toileted. The 5/13/25 PT evaluation and plan of treatment and three PT skilled service notes, dated 5/13/25, 5/14/25 and 5/19/25, were provided by the NHA on 5/22/25 at 1:05 p.m. The PT evaluation and plan of treatment identified Resident #28 was evaluated on 5/13/25. -The resident was not evaluated by PT until 12 days after the physician recommended a PT evaluation (on 5/1/25) and after the resident had three falls on 5/6/25, 5/9/25 and 5/10/25 (see above). The provided PT notes identified Resident #28 needed reminders and cueing for safety. The 5/14/25 PT skilled services note revealed Resident #28's four-wheel walker brakes were significantly loose and ineffective. The note identified PT replaced the walker with a different four-wheel walker from the facility's storage and adjusted it for the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 5/21 at-risk meeting minutes documented Resident #28 completed her round of antibiotics for her UTI and fall interventions remained in place and were effective because she had had no further falls. -However, the facility failed to identify the resident had a UTI, ensure effective interventions were in place and obtain a PT evaluation until after Resident #28 sustained three consecutive falls in four days, one of which resulted in the resident being transferred to the hospital where she received two staples for a head laceration (see record review above). D. Staff interviews The NHA, the director of nursing (DON) and the corporate consultant (CC) were interviewed together on 5/22/25 at 12:12 p.m. The NHA said falls were reviewed the next business day at the at-risk meeting. He said the IDT reviewed current fall interventions, the root cause of the fall and what new intervention would be implemented. The NHA said over the last review months, the facility had implemented a fall reduction staff incentive plan to help reduce the occurrence of falls. The DON said the staff was trained to watch for clutter on the floor, conduct frequent rounding and make sure the residents' basic needs were met. The NHA said all new fall interventions were communicated through the facility's online communication board, verbal communication and the residents' care plans. The NHA said the former DON used to lead the facility's fall review and oversight. The NHA said the current DON was new to her position and would be trained to take over the fall program. The NHA said Resident #28 was found on the floor on 5/6/25 putting on her shoes. He said the IDT determined a shoe rack by her bed within her reach could help reduce a similar fall. He said he believed the shoe rack was in place. The DON said a shoe rack was not ordered yet. The CC said the shoe rack would be ordered today (5/22/25). The NHA reviewed the 5/6/25 progress note identifying the nurse thought Resident #28's fall was possibly contributed to the resident's walker sliding back, resulting in the resident on the floor. The NHA said he would look into Resident #28's walker. He said the resident was currently on the therapy caseload. He said he was not sure what the PT's fall interventions were at this time. The CC said all of Resident #28's falls were in the early morning. She said she did not see interventions specific to fall risks in the early morning hours. The CC said the resident was identified to have high blood pressure and a UTI after the falls. The CC said she did not see the staff identified what footwear Resident #28 was wearing when she fell on 5/6/25. The CC said Resident #28 did not have the right socks on when she fell on 5/9/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA said he was not sure if socks were identified as a concern or if staff was educated on the need for non-skid socks after the 5/9/25 fall. The NHA said the IDT discussed providing Resident #28 more assistance in the early mornings. The DON said staff should be checking on residents during rounding every hour making sure needs were met and checking for safety. She said Resident #28 should have been checked on more frequently on the nights before she fell. The DON said Resident #28 would need staff assistance to get dressed. The DON said after the 5/10/25 fall, Resident #28 was placed on a toileting program. She said the resident would be offered toileting when she woke up, before and after meals and at bed time. She said the staff would offer the resident toileting assistance if she woke up in the middle of the night. The NHA said red lights were installed in resident rooms to help residents see at night a couple of years ago. He said he did not know if the red lights were on at the time of Resident #28's falls. The CC and the NHA said they would look at the lighting in Resident #28's room, the status of her shoe shelf and her walker. The NHA and the CC said staff would be educated on non-skid sock use and rounding hourly.

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	065253	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Villa Grande Care Center	2501 Little Bookcliff Dr Grand Junction, CO 81501

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%). Specifically, the facility's medication error rate was 7.69%, which was two errors out of 26 opportunities for error. Findings include: I. Medication administration observations On 5/21/25 at 9:35 a.m. registered nurse (RN) #3 was preparing and administering medications for Resident #15. Resident #15 had physician's orders for the following medications: Carboxymethylcellulose-Glycerin ophthalmic gel 1-0.9 % (Genteal moisturizing gel), instill one drop to each eye twice a day for dry eyes, ordered 5/14/24. -However, RN #3 administered Hypromellose/Dextran/Glycerin ophthalmic eye drops (Genteal moisturizing eye drops) to Resident #15 instead of the Genteal moisturizing gel specified in the physician's order. Calcium Carbonate chewable tablet 500 milligrams (mg), give one tablet by mouth three times a day, ordered 3/7/24. RN #3 attempted to administer a Calcium Carbonate chewable tablet 500 mg as ordered by the physician to Resident #15. Resident #15 declined to take the medication and requested to keep the medication on her bedside table. RN#3 left the medication at the resident's bedside, exited the resident's room and returned to her medication cart. Review of Resident #15's May 2025 medication administration record (MAR) revealed RN #3 documented the resident's scheduled morning dose of Calcium Carbonate chewable tablets as administered. -However, Resident #15 had not taken the medication when RN #3 attempted to administer it to her (see observation above). Cross reference F554 for failure to ensure Resident #15 was assessed and a physician's order obtained for self-administration of medications. II. Staff interviews RN #3 was interviewed on 5/21/25 at 9:50 a.m. RN #3 said Resident #15 frequently asked for the Calcium Carbonate chewable tablets to remain at the bedside so she could self-administer them at a later time. RN #3 said the resident was a retired nurse and was particular about her medications. The consulting pharmacist was interviewed on 5/22/25 at 10:44 a.m. The consulting pharmacist said Genteal eye gel and Genteal eye drops provided the same overall effect; however, the Genteal eye gel had a longer lasting effect compared to the eye drops. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) and the corporate consultant (CC) were interviewed on 5/22/25 at 4:01 p.m. The DON said the nursing staff should contact the physician to clarify the physician's order prior to administering a medication if the medication order did not match the medication available. The DON said RN #3 should have witnessed Resident #15 consuming the medication in order to document it in the MAR as administered. She said if a resident requested to self-administer the medication at a later time, the nurse should not document the medication as administered.

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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. Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures. Specifically, the facility failed to ensure resident food was palatable in temperature and taste. Findings include: I. Facility policy and procedure The Assistance with Meal policy, revised March 2022, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. The policy read in pertinent part, Hot food shall be held at a temperature of 135 degrees or above until served. Cold food shall be held at 41 degrees or below until served. Nursing and dietary services will establish procedures such that delivery of food to serving areas accommodates this requirement. II. Resident interviews Resident #53 was interviewed on 5/19/25 at 11:02 a.m. She said the food could taste better. Resident #58 was interviewed on 5/19/25 at 11:38 a.m. He said about three times a week the hot food was not hot or warm. Resident #44 was interviewed on 5/19/25 at 5:47 p.m. He said meat at the facility was always too dry and did not have any taste to it. Resident #20 was interviewed 5/20/25 at 9:36 a.m. She said sometimes the food did not taste good. II. Resident council minutes The March 2025 resident council minutes documented some of the residents told the dietary manager (DM) the meals were lukewarm. According to the minutes, the DM told the council she would make sure the meals were at the correct temperatures for the residents. The April 2025 resident council minutes documented on occasion the food could be hotter. According to the minutes a few residents said on occasion the meals served in the dining room were not hot enough. Some of the residents who were served meals in their room said the meals were often lukewarm and not very hot. III. Observations During a continuous observation on 5/19/25, beginning at 12:00 p.m. and ending at 12:32 p.m. the following was observed during room tray delivery in the north hall: At 12:01 p.m. the room tray meal cart arrived at the north hall. At 12:02 p.m. the cart sat in the hall while an unidentified staff member answered a call light. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:07 p.m. the staff started serving the room trays down the north hall. At 12:32 p.m. all room trays on the north were delivered. -The observation on the north hall identified the room tray cart sat in the hall for six minutes before delivery began. During a continuous observation on 5/21/25, beginning at 11:31 a.m. and ending at 12:09 p.m., the following was observed during room tray delivery in the north hall: At 11:57 a.m. the test tray was plated and placed on the room tray cart for delivery to south hall. At 12:06 p.m. the remainder of the plated and ready resident's room trays were loaded on cart. At 12:09 p.m. the cart door remained open until the cart left the kitchen and proceeded to the south hall. At 12:10 p.m. the room tray cart arrived in the south hall. At 12:15 p.m. the staff began passing the room trays. At 12:50 p.m. the last resident received their room tray and the test tray was pulled from the room tray cart and the temperature of the meal was immediately taken. -The room tray delivery began in the south hall five minutes after it arrived. IV. Test tray A test tray for a regular diet was evaluated immediately after the last resident had been served their room tray for lunch on 5/20/25 at 12:55 p.m. by four surveyors: The test tray was not served at palatable food temperatures and consisted of Salisbury steak, oven-fried potatoes, spinach, chicken and rice stew and a slice of coconut pie. -The Salisbury steak with gravy was 111.6 degrees Fahrenheit (F). The Salisbury steak was salty. -The oven-fried potatoes were 103 degrees F. The potatoes were not crispy and had a mushy texture. -The spinach was 109.5 degrees F. The spinach was watery. -The chicken and rice stew was 114.3 degrees F. The stew was bland. -The slice of coconut pie was 67.2 degrees F. The pie was not cold in taste. Each of the meal items of the test tray were cold or lukewarm in temperature. V. Staff interviews (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 5/21/25 at 3:26 p.m. She said the CNAs and the nurses should deliver the meal trays when the cart arrived at the hall. The DON said if the staff delivered the room trays in a timely manner they could provide meal assistance in other areas and help ensure appropriate temperatures of the room tray meals. The registered dietitian (RD) was interviewed on 5/21/25 at 2:11 p.m. The RD said if a meal was not warm enough when it was eaten, it would not be as delicious as it could be. The DM was interviewed on 5/22/25 at 1:23 p.m. The DM said she had heard from residents that the pork was too tough and temperatures for the room trays were on the cooler side. She said to help with the tough pork she began ordering pork from a different source. She said to help with room tray temperatures she observed the meal tray delivery times and identified some long waits before the trays were served. She said she had spoken to the former DON and was told the nursing staff would pass the trays in the halls as soon as the room tray cart would arrive to help maintain the meal temperatures. The DM said during the 5/22/25 lunch observation, the dietary staff was making a grilled cheese to be placed on the room tray cart. She said during that time the room tray cart was left open.The DM said the south hall cart door should have been closed and quickly delivered to the south hall to help maintain temperatures of the rest of the room trays. She said the alternate meal should have been sent separately after it was ready. The DM said the coconut cream pie served at 67.2 degrees, which was too warm. She said she believed the pie contained dairy and should have been served at 41 degrees F or less. She said cold food should remain cold to ensure palatable temperatures. She said she would look at placing room tray cold food items in coolers with ice until they are delivered to the residents' room. The DM was interviewed again on 5/22/25 at 2:31 p.m. She said she would provide education to the cooks to help improve food palatability.

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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. II. Failure to use consistent hand hygiene practices when providing meal assistance A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Handwashing Facts dated 4/17/24, retrieved on 6/1/25 from https://www.cdc.gov/clean-hands/data-research/facts-stats/index.html, Hand washing with soap removes germs from hands. This helps prevent infections because people frequently touch their eyes, nose and mouth without even realizing it. Germs get into the body through the eyes, nose and mouth and make us sick. Germs from unwashed hands can get into food and drinks while people prepare or consume it. Germs can multiply and some types of foods or drinks, under certain conditions and make people sick. Germs from unwashed hands could be transferred to other objects and then transferred to another person's hands. B. Facility policy and procedure The Handwashing/Hand Hygiene policy, dated 2001, was provided by the nursing home administrator (NHA) on 5/22/25 at 2:45 p.m. The policy read in part, This facility considers hand hygiene the primary means to prevent the spread of health care associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. C. Observations On 5/20/25 during a continuous observation of the lunch meal on the memory care unit, beginning at 11:55 a. m. and ending at 1:17 p.m., the following was observed: At 11:55 a.m. CNA #13 was assisting residents, at the assisted dining table and other more independent residents in the dining room. At 12:15 p.m. CNA #13 sat down at the assisted dining table between Resident #49 and Resident #70 and across from Resident #36. She used alcohol-based hand rub (ABHR) from her pocket before assisting the residents. At 12:21 p.m. CNA #13 touched the side of her nose and dropped a pen on the floor. CNA #13 picked up the pen off the floor and proceeded to provide meal assistance and touch the fork of Resident #49 before she used ABHR again. At 12:31 p.m. CNA #13 dropped the ABHR cap on the floor. She picked up the cap off the floor. CNA #13 did not reapply ABHR after picking up the item off the floor. CNA #13 proceeded to offer Resident #36 a sip of her beverage, touching the resident's cup in the process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:33 p.m. CNA #13 assisted Resident #70 with positioning her cup and then performed hand hygiene with the ABHR. CNA #13 did not perform hand hygiene before helping the two residents or in between assisting each resident. At 12:36 p.m. a second CNA (CNA #14) sat down between Resident #49 and Resident #36. CNA #14 provided meal assistance to Resident #49 and helped position a utensil in Resident #36's hand. CNA #14 did not perform hand hygiene in between assisting the two residents. D. Staff interviews CNA #14 was interviewed on 5/20/25 at 1:16 p.m. CNA #14 said staff should perform hand hygiene between assisting different residents. CNA #14 said she did not have ABHR with her. She said her ABHR was in her back pack and the facility was out of ABHR in the supply cabinet. CNA #14 said she was primarily providing meal assistance for Resident #49. She said she only provided cueing for Resident #36. -However, CNA #14 assisted Resident #36 with positioning a utensil in her hand (see observations above). CNA #13 was interviewed on 5/20/25 at 1:18 p.m. CNA #13 said staff should perform hand hygiene before serving each resident food and between assisting residents with their meals. The IP was interviewed on 5/21/25 at 3:08 p.m. The IP said staff should perform hand hygiene before assisting residents with their meals, between passing trays and between assisting multiple residents. The IP said hand hygiene should be conducted anytime there was a risk of cross-contamination, including after picking something off the floor. She said she had recently observed staff and conducted oversight in the main dining room during meals but had not observed any concerns. She said she would provide on the spot education with staff if she saw hand hygiene concerns. She said she had not recently observed staff's hand hygiene practices in the memory care unit. The IP said she would immediately have hand hygiene education conducted with staff. The director of nursing (DON) was interviewed on 5/21/25 at 3:26 p.m. The DON said staff were provided hand hygiene training when hired and anytime there was an outbreak. She said she did not know when the staff last had hand hygiene training. The DON said cross-contamination could occur if staff picked up an item off the floor and did not perform hand hygiene when providing meal assistance to residents. She said she would ensure hand hygiene education was conducted with staff. The CC was interviewed on 5/22/25 at 10:37 a.m. The CC said she could not find any recent training that had been provided to staff regarding performing hand hygiene when assisting residents with meals. Based on observations and interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections on four of four hallways. Specifically the facility failed to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ensure an effective process was in place to ensure staff were aware of which residents were on enhanced barrier precautions (EBP); -Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing direct care to residents who should be on EBP; and, -Ensure staff performed consistent hand hygiene when providing meal assistance to residents. Findings include: I. EBP failures A. Facility policy and procedure The Infection Prevention and Control Program policy and procedure, dated December 2023, was provided by the nursing home administrator (NHA) on 5/22/25 at 6:00 p.m. It read in pertinent part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Important facets of infection prevention include identifying possible infections or potential complications of existing infections; instituting measures to avoid complications or dissemination; educating staff and ensuring that they adhere to proper techniques and procedures and implementing appropriate enhanced barrier and transmission based precautions when necessary. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. The facility provides personal protective equipment and checks for its proper use. B. Observations On 5/19/25 at 4:38 p.m. Resident #83's and Resident #6's room was observed. Resident #83 had a urinary catheter and Resident #6 had a Stage 2 pressure ulcer on the left buttock. There was no PPE inside or outside of the room for staff to put on when providing direct care to the residents. On 5/19/25 at 5:40 p.m. Resident #44's room was observed. Resident #44 had a catheter and multiple pressure wounds. There was no PPE inside or outside of the room for staff to put on when providing direct care to the resident. On 5/20/25 at 11:39 a.m. Resident #44's room was observed again. There was no PPE inside or outside of the room for staff to put on when providing direct care to the residents. Resident #44 was lying in bed watching television. Two unidentified staff members entered the room with a mechanical lift to get Resident #44 out of bed. -The two unidentified staff members did not don PPE before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:43 a.m. both unidentified staff members exited the room with Resident #44 in his wheelchair. One of the unidentified staff members wheeled Resident #44 to the dining room. On 5/21/25 at 1:15 p.m. Resident #83 and Resident #6's room was observed. There was no PPE equipment inside or outside of the room for staff to put on when providing direct care to the residents. On 5/21/25 at 1:18 p.m. Resident #58's room was observed. Resident #58 had a catheter. There was no PPE inside or outside of the room for staff to put on when providing direct care to the resident. C. Resident interview On 5/21/25 at 1:55 p.m. a resident who wished to remain anonymous was interviewed. The resident said staff did not put a gown on when providing care for them. The resident said a bin with PPE equipment was recently brought to their room. The resident said during their showers, staff wore gloves and masks but did not put on a gown when providing the resident with a shower. D. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 5/21/25 at 4:11 p.m. CNA #6 said she had never heard of a resident being placed on precautions requiring PPE because of having a catheter. CNA #6 said when providing care for residents who had a catheter the only PPE she used was gloves. CNA #6 said she did not have to use additional PPE when draining a catheter bag or when providing care to the resident. She said she had never worn a gown when providing care for a resident who had a catheter. CNA #6 said for residents who had pressure ulcer wounds, the only PPE she would use was gloves. CNA #6 said if there was no precaution sign on a resident's door she just used gloves to provide care for residents. CNA #6 said there were no residents who were on EBP in the facility. Registered nurse (RN) #2 was interviewed on 5/21/25 at 4:44 p.m. RN #2 said residents who had a catheter should be on standard precautions, which only required the use of gloves when providing care. RN #2 said staff should be using gloves when providing care to all residents. RN #2 said staff should be using gloves when providing care to residents who had a closed wound. RN #2 said if a resident's skin was not intact and open, the resident was at high risk for infection, so she said she would wear a gown and goggles when providing care. She said there were no residents in the facility who were on EBP. The infection preventionist (IP) and the corporate consultant (CC) were interviewed together on 5/22/25 at 3:13 p.m. The IP said she was responsible for initiating EBP for residents. IP said signs should be placed on the residents' doors and bins placed with PPE. The IP said signs placed on residents' doors were important so that staff were aware of what kind of PPE they should be using when providing care for the residents. The IP said residents who had a catheter or pressure ulcer should be placed on EBP.staff should be wearing gloves and gowns when providing direct care to the residents. The IP said she started providing education to all staff on EBP on 5/21/25.