STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065257	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Storybrook Care & Rehabilitation	1005 E Elizabeth St Fort Collins, CO 80524

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48112 Based on record review and interviews, the facility failed to provide a response, action and rationale to residents involved in group grievances. Specifically, the facility failed to: -Allow the resident council to meet without a staff member present; -Provide a private space for resident council; and, -Provide a response, action and rationale for food concerns. Findings include: I. Facility policy and procedure The Resident Council Meetings policy, revised June 2024, was provided by the nursing home administrator (NHA) on 9/19/24 at 3:15 p.m. It read in pertinent part, The facility shall act upon concerns and recommendations of the council, make attempts to accommodate recommendations to the extent practicable, and communicate its decision to the council. II. Resident group interview A group interview was conducted on 9/18/24 at 10:07 a.m. with five residents (#11, #14, #17, #31 and #35), who were identified as alert and oriented through facility and assessment. Resident #31 and Resident #11 said the resident council meeting was held in the large dining room. Resident #11 said the door was left open. Resident #11 said staff, visitors and residents came in and out of the room during the meeting. Resident #31 said the facility staff attended the meeting and they were not given an opportunity to talk without staff present at resident council meetings. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #31 said the staff listened to their concerns but did not provide an action to resolve their concern. Resident #31 said she was a vegetarian. She said the facility did not provide a lot of vegetarian protein choices for her meals. Resident #31 said she was served a lot of grilled cheeses as her meals. Resident #11 and Resident #17 said there were not a lot of desserts that were appropriate for a diabetic diet. Resident #17 said she had a lot of jello and pudding. Resident #11 said she wanted sugar free pies, cakes and cookies. Resident #17 and Resident #35 agreed with Resident #11. Resident #11, Resident #17, Resident #31 and Resident #35 said the food was overcooked and watery. The residents said they did not feel the facility provided prompt resolutions to their concerns. III. Resident council notes The July 2024 resident council meeting notes were requested. A resident council concern form was provided. It revealed residents wanted more food varieties and consistency. The staff response section revealed the dietary manager (DM) would attend the resident council meetings. -The recommendation and solution section was left blank. The resident council approval date section was left blank. -There was no documentation indicating the residents were offered the opportunity to meet without staff present. The 8/7/24 resident council meeting notes revealed the residents said the food was awful, there was too much seasoning and the soup was watery. It also documented the residents requested more diabetic dessert options and would like sugar free hot chocolate. The response for more diabetic desserts indicated the (DM) would look into adding more diabetic desserts to the menu. The DM said there was sugar free hot chocolate, but the residents had to ask for the sugar free hot chocolate. The DM said they would speak to the cooks and come up with suggestions on how to improve the food. The dietary response for the watery soup was the residents would tell the DM when they received watery soup so she could see who was cooking and educate the cook. -However, there was no documentation indicating the residents approved the food concerns brought up in the 8/7/24 resident council meeting. - There was no documentation the residents were offered the opportunity to meet without staff present. Resident council notes from 9/4/24 revealed residents said there was too much pepper in the food, soup was water, roasts too tough, wanted more fresh fruit and sugar free ice cream. The recommendation section said the dietary manager was notified. The staff response section said the DM would talk to staff about less pepper. The DM said the soup was not too watery because it was soup and not a stew. The DM said she would see if fresh fruit could fit in the budget, would look into sugar free ice cream and residents could buy their own food and keep the food at the nurse's station refrigerator and freezer. -However, there was no documentation residents approved the 8/7/24 food concern. -There was no documentation residents were offered the opportunity to meet without staff present. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews The activities director (AD) was interviewed on 9/19/24 at 11:29 a.m. The AD said she had been in her position for approximately three months. She said the NHA and the clinical resource consultant (CRC) helped her coordinate the resident council meeting. The AD said the resident council agenda started with the residents talking about dietary comments, concerns or suggestions. She said the meeting continued with a topic such as what was resident council, then she asked for general comments, concerns or suggestions. She said the topic was provided by the NHA and the last resident council topic was the purpose of resident council. The AD said the resident council meeting was held in the dining room and the dining room doors are left open. The AD said she did not ask if the residents wanted to meet without staff present. She said when a resident brought a concern up during resident council meeting she told the department head and asked what the timeline was to resolve the concern. The AD said she went over the department's response in the next resident council meeting. The AD said she did not ask the resident council if they approved the response. The AD said the food concerns were not resolved. The AD said there was no documentation indicating the resident council approved the food concern responses. The DM was interviewed on 9/18/24 at 12:14 p.m. The DM said she e was aware of the concerns residents brought up at the recent resident council meeting. The DM said the resident council did not approve the responses she provided to their concerns. The DM said she would follow up with the residents to come up with a solution. The NHA was interviewed on 9/19/24 at 11:57 a.m. The NHA said the AD was responsible to coordinate the resident council meeting. He said the agenda consisted of covering a topic, such as what was resident council. He said the residents were given an opportunity to voice their concerns. He said resident council were offered to meet without staff present and the dining room door should be closed. The NHA did not know the AD did not provide the residents the opportunity to meet without staff present and the door was not closed. He said the resident council concerns were reviewed in the morning meeting the day after resident council was held. He said the department head had five days to resolve the concern. The NHA said the AD went to the resident council's president to ensure the resolution was approved. The NHA said he did not know the AD did not go over the concerns with the president. The NHA said he reviewed the 7/3/24 resident council concern form. The NHA said the form should have been completed to ensure the resident council approved the residents concerns. The NHA said he reviewed the 8/7/24 resident council minutes. The NHA said there was no documentation the residents were offered to meet without staff present and the resident council approved the staff response to the residents concerns. The NHA said he reviewed the 9/4/24 resident council minutes. The NHA said there was no documentation the residents were offered to meet without staff present and the resident council approved the staff response to the residents' concerns. The NHA said he would work with the AD to ensure the residents were offered the opportunity to meet without staff present and to ensure the dining room door is closed during the resident council. The NHA said he would work with the AD to ensure the resident council approved the staff response to the residents' concerns.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 48112 Based on record review and interviews, the facility failed to provide ongoing communication to residents about their rights; and failed to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Specifically, the facility failed to provide ongoing communication and discussion to the resident's about their rights and responsibilities. Findings include: I. Facility policy and procedure The Resident Rights policy, revised August 2024, was provided by the nursing home administrator (NHA) on 9/19/24 at 3:15 p.m. It read in pertinent part, Information about resident rights and responsibilities will be given to the resident both orally and in writing. II. Resident group interview A group interview was conducted on 9/18/24 at 10:07 a.m. with five residents (#11, #14, #17, #31, and #35), who were identified as alert and oriented through facility and assessment. Resident #11, Resident #17, Resident #31 and Resident #35 said the facility did not provide ongoing discussion to review and explain their resident rights and responsibilities. The residents who attended the group meeting said they did know their rights as residents. The residents said they did not know the resident rights were posted on a wall in the facility. The rights were posted on the wall on the left side of the doors to the dining room. The residents said they wanted to know what their rights were so they could ensure the facility honored their rights. III. Record review The resident council monthly minutes from July 2024 through September 2024 were provided by the activities director (AD) on 9/18/24. The minutes revealed there was no documentation indicated the rights of residents were discussed and reviewed. IV. Staff interviews The AD was interviewed on 9/19/24 at 11:29 a.m The AD said she did know when resident rights were reviewed with residents. The AD said she assisted in running the resident council meetings monthly. She said the resident rights were not reviewed during resident council. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 9/19/24 at 11:57 a.m. The NHA said the resident rights were reviewed verbally and in writing with the resident and the family at admission. He said there was a big poster on the wall next to the dining room. He said resident rights were not discussed at the resident council. The NHA said he would work with the AD to ensure rights were reviewed on an ongoing basis and documented in the resident council minutes.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on observations, record review, and interviews the facility failed to provide a prompt effort to resolve grievances for one (#28) and the resident group out of 19 sample residents. Specifically, the facility failed to: -Follow through on grievances for lost/stolen items for and #28; and, -Ensure the residents had information on how to file a grievance. Findings include: I. Facility policy and procedure The Resident and Family Grievances policy and procedure, dated January 2023, was provided by the regional clinical resource (RCR) on 9/19/24 at 4:00 p.m. It read in pertinent part, It is the policy of this facility to support each resident's and family member's right to voice grievances with prompt effort to resolve. Information on how to file a grievance or complaint will be available to the resident. The Resident Personal Belongings policy and procedure, dated April 2022, was provided by the regional clinical resource (RCR) on 9/19/24 at 4:00 p.m. It read in pertinent part, It is the policy of this facility to protect the resident's right to possess personal belongings. All resident personal items will be inventoried at the time of admission. Additional possessions brought into the facility shall be added to the existing personal belongings inventory listing. The facility will exercise reasonable care for the protection of the resident's property from loss or theft. II. Failure to address Resident #28's grievances A. Resident #28 1. Resident status Resident #28, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included epileptic seizures and major depressive disorder. The 6/6/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. 2. Resident interview (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 interviewed on 9/16/24 at 11:00 a.m. Resident #28 said he had a local sports team sweatshirt stolen out of his closet. Resident #28 said he also had a cotton towel stolen from off of his bed. Resident #28 said he had cash stolen from his room twice totaling $100.00. Resident #28 said many of his shirts go out to the laundry and do not come back. Resident #28 said he had filed many grievances without resolution. 3. Record Review The resident personal belongings inventory, dated May 2024, was provided by the nursing home administrator (NHA) on 9/18/24 at 9:00 a.m. It indicated the resident had eyeglasses, upper and lower dentures, chase debit card, one pair of gloves, one hat, five sweatpants, seven shirts, one pair white sneakers, eight pairs of socks, seven jackets/flannels, three shorts, one suitcase, one wooden box, one blanket, one dodge caravan, one fossil kit, one broken laptop and one model car. The September 2024 resident council meeting notes dated 9/4/24 provided by regional clinical resource (RCR) on 9/18/24 at 9:00 a.m. The notes revealed Resident #28 had reported on 9/4/24 during the resident council meeting that he had some clothing that had been stolen from his room. The notes documented social services notified. Grievances related to missing/stolen items for Resident #28 were requested on 9/17/24 for Resident #28. The facility did not provide documentation indicating they had attempted to resolve the resident's concern regarding missing clothing (see interview below). B. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 9/18/24 at 3:33 p.m. CNA #1 said if a resident reported missing items she would look in the trash can, dirty laundry and linen. CNA #1 said she would fill out a grievance form for social services. CNA #2 was interviewed on 9/18/24 at 3:35 p.m. CNA #2 said if property was reported missing or stolen she would notify the nurse and administration. The RCR interviewed on 9/19/24 at 12:54 p.m. The RCR was covering for the DON who was on vacation at the time of the survey. The RCR said she did not believe that any items had been missing or stolen from Resident #28. The RCR said we could not show he ever had the items. The RCR said the facility could not show the items went missing either. The RCR said Resident #28 had a current increase in external stressors and had become fixated on items. 48112 III. Failure to ensure residents had information on how to file a grievance A. Resident group interview A group interview was conducted on 9/18/24 at 10:07 a.m. with five residents (#11, #14, #17, #31 and #35), who were identified as alert and oriented through facility and assessment. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11, Resident #17, Resident #31 and Resident #35 said they did not know how to file a grievance. After the group interview, Resident #17 and Resident #31 saw where the grievance form and grievance policy were located. Both residents said they did not know the grievance forms were in front of the social services office. Resident #31 said the grievance policy's font was too small to read. B. Observations On 9/16/24 at 8:30 a.m. an observation was conducted throughout the facility. There was a grievance policy located on the wall between the NHA's office and the social services office. The policy was in four frames sized eight and a half by 11 inches. The font size was approximately 10 to 12. The policy was displayed vertically from the ceiling to the middle of the wall, approximately at eye level for someone in a wheelchair. There was a wire mesh wall file on the left side wall of the social services office. There were grievance forms in the wall file. There were no signs around the wall file to say what the papers in the wall file were for. On 9/19/24 at 11:00 a.m. a sign was posted above the grievance forms to the left of the social services office on how to file a grievance form. C. Staff interviews The NHA was interviewed on 9/18/24 at 9:54 a.m. The NHA said there was not a sign next to the grievance forms (see observations above). The NHA was interviewed again on 9/19/24 at 11:57 a.m. The NHA said the social services director (SSD) was for managing grievances. The NHA said the SSD was unavailable to interview due to illness during the survey period. He said there should have been a sign next to the grievance form to indicate the mesh file held grievance forms. He was not aware the residents said the policy posted was too small to read. The NHA said he would fix it.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record reviews and interviews, the facility failed to incorporate the recommendations from the preadmission screening and resident review (PASRR) level II determination and evaluation report into the assessment, care planning and transition of care for one (#14) of one resident reviewed for PASRR out of 19 sample residents. Specifically, the facility failed to -Take steps to ensure services were provided as recommend in Resident #14's PASRR level II report; and, -Develop and implement a care plan to identify the PASRR level II recommendations for Resident #14. Findings include: I. Facility policy and procedure The Resident Assessment: Coordination with PASRR Program policy, revised 8/2024, was provided by the nursing home administrator (NHA) on 9/19/24 at 3:15 p.m. It read in pertinent part, Recommendations, such as any specialized services, from a PASRR level II determination will be incorporated into the resident's assessment, care planning, and transitions of care. II. Resident #14 A. Resident status Resident #14, age 72, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included, bipolar disorder (mental illness that causes unusual shifts in behavior), post-traumatic stress disorder (PTSD), alcohol abuse, nicotine dependence, stimulant use, cerebral infarction due to occlusion or stenosis of small artery (stroke), dementia, stage three kidney disease and intervertebral disc disorders with myelopathy (spinal cord injury when the spinal cord was compressed). The 8/5/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required partial assistance with toileting and dressing. He required complete assistance for showering and set up assistance for eating, oral hygiene and personal hygiene. B. Record review Resident #14 PASRR level II, dated 7/24/24, revealed the resident had a PASRR condition and required specialized services. The specialized services required were case management, psychiatric case consultation and individual therapy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of the comprehensive care plan, dated 9/19/24, revealed there was no documentation regarding the resident's PASRR level II screening and specialized service recommendations for mental illness. A social services assessment was completed on 7/25/24. -The psychological and psychiatric section of the assessment revealed there was no documentation of a psychiatric diagnosis. However, the resident had a diagnosis of bipolar disorder and PTSD. -A review of the electronic medical record (EMR) from 7/25/24 to 9/19/24 did not reveal documentation that indicated the resident was receiving case management, psychiatric case consultation or individual therapy as recommended on the 7/24/24 PASRR level II determination. C. Staff interview The regional clinical resource (RCR) and the NHA were interviewed together on 9/19/24 at 12:12 p.m. The RCR said a care assessment was completed within 21 days from the residents admitted . The RCR said if the resident was already determined to have a level II assessment based on the level I assessment, the facility would follow the plan. The RCR said the facility identified residents with newly evident or possible mental disorder, intellectual disease or related disease during the monthly psych pharm meeting. The RCR said the DON and the social services director (SSD) collaborated together during the psych pharmacological meeting. The RCR said the SSD was responsible for making the referral to the appropriate authority based on the level II determination. The NHA said the SSD was unavailable during the survey period. The RCR said the facility followed the recommendations from the PASRR level II determination. She said the SSD documented the recommendations in the social services assessment and in the resident's comprehensive care plan. The RCR said the recommendations from Resident #14's level II PASRR were not included in the social services assessment that was completed on 7/25/24. The RCR said the level II PASRR recommendations were not included on the resident's care plan until 9/19/24 (during the survey). The NHA said the facility worked with an independent psychiatrist to provide the recommendations in the PASRR level II determination. The NHA said she was unsure why Resident #14's level II PASRR recommendations were not implemented. The RCR said the appointment was scheduled on 7/30/24. The RCR said there was no documentation indicating the resident attended the appointment on 7/30/24. The RCR said a new appointment was scheduled and the earliest available appointment was for 10/3/24. The RCR said it was important to ensure the PASRR level II recommendations were included in the resident's comprehensive care plan because it helped manage the resident's behavior and assist the resident in the best way possible.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on interviews, observations, and record review, the facility failed to ensure one (#5) of two residents reviewed for pressure injuries out of 19 sample residents received the necessary treatment and services to prevent the development of pressure injuries. Resident #5, who had a diagnosis of multiple sclerosis (an immune disease that disrupts nerve communication between the brain and the body) and generalized muscle weakness, was admitted to the facility on [DATE] for ongoing medical management and rehabilitation after a tibial and fibular fracture. Resident #5 was admitted to the facility with intact skin of the feet and heels. On 4/25/24 Resident #5 was assessed for risk of developing pressure injuries and was identified as moderate risk due to a history impaired mobility and bowel incontinence. The facility initiated a skin care plan for pressure injury risk, however, the care plan did not include specific interventions to prevent pressure injuries from developing on the resident's feet. On 6/3/24 a physician's order was obtained for Resident #5 to wear off-loading boots on both feet at all times. However, multiple observations during the survey (from 9/16/24 to 9/19/24) revealed staff was not consistently implementing the intervention (see observations below). On 8/23/24 Resident #5 was noted to have an unstageable pressure injury to the plantar surface of her left foot. Due to the facility's failure to implement timely and effective pressure injury interventions and ensure that staff were consistently implementing Resident #5's offloading boots, the resident developed a facility-acquired unstageable pressure injury to the plantar surface of her left foot. Findings include: I. Professional reference A. Classification of pressure injuries According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://internationalguideline.com/2019 on 9/23/24, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Skin Assessment policy and procedure, dated January 2023, was provided by the regional clinical resource (RCR) on 4/19/24 at 4:00 p.m. It read in pertinent part, It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. A head to toe skin assessment will be conducted by a licensed or registered nurse (RN) upon admission, readmission, daily for three days, and weekly thereafter. The Wound Treatment Management policy and procedure was provided by the RCR on 4/19/24 at 4:00 p.m. It read in pertinent part, To promote wound healing it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. III. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis, generalized muscle weakness and myoclonus (sudden involuntary muscle spasms). The 6/17/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed the resident was a substantial/maximal status and required two staff assistance for transfers with a hoyer lift. The MDS assessment revealed Resident #5 was at risk for the development of pressure injuries. B. Resident observations and interviews On 9/16/24 at 9:40 a.m. Resident #5 was lying in bed. The resident's feet and heels were not off-loaded. Her off-loading boots were on the dresser. Resident #5 said she developed a wound on her left foot after her admission to the facility. Resident #5 said she had seen a wound care doctor regularly since she developed the wound. On 9/16/24 at 12:52 p.m. Resident #5 was sitting in her wheelchair in the dining room with her feet resting on the foot pedals of the wheelchair. The resident was wearing an offloading boot on her left foot. The resident's right foot did not have an offloading boot on it. -However, according to the September 2024 CPO, Resident #5 was supposed to wear offloading boots on both feet at all times (see physician's order below). On 9/17/24 at 10:51 a.m. Resident #5 was lying in bed. Her feet and heels were not off-loaded and her off-loading boots were on the dresser. On 9/17/24 at 1:04 p.m. Resident #5 was sitting in her wheelchair in the dining room with her feet resting on the foot pedals of the wheelchair. The resident was wearing an offloading boot on her left foot. The resident's right foot did not have an offloading boot on it. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-However, according to the September 2024 CPO, Resident #5 was supposed to wear offloading boots on both feet at all times (see physician's order below). On 9/18/24 at 9:53 a.m. Resident #5 was lying in bed. Her feet and heels were not off-loaded and her off-loading boots were on the dresser. Resident #5 said she developed a blood blister on her left foot after admitting to the facility. Resident #5 said she was supposed to wear special off-loading boots while she was out of bed in her wheelchair. On 9/18/24 at 11:20 a.m. Resident #5 was lying in bed. Her feet and heels were not off-loaded and her off-loading boots were on the dresser. Registered nurse (RN) #2 entered the resident's room to perform wound care on the resident's left foot wound. The wound was located on the ball of Resident #5's left foot, just under her toes and was an oval shaped area of skin, dark purple in color, approximately the size of an egg. Resident #5 said she had limited sensation in her legs and feet which felt like pins and needles with a burning sensation. C. Record Review Resident #5's skin care plan, updated 8/30/24, revealed the resident was at risk for pressure ulcer development related to impaired mobility and bowel incontinence. Interventions included following policies and protocols for the prevention of skin breakdown (initiated 5/5/24), following treatment orders for the left plantar pressure ulcer (initiated 8/30/24), following with the wound care provider (WCP) until wound healed (initiated 8/30/24), and providing a supplemental protein to promote wound healing (initiated 8/30/24). -The care plan did not document specific interventions for offloading the resident's feet to prevent pressure injury development. Review of Resident #5's August 2024 CPO revealed the following physician's order: Barrier cream to wound on left foot, cover with foam dressing, ordered 8/23/24 and discontinued 8/29/24. Review of Resident #5's September 2024 CPO revealed the following physician's orders: Offloading boots at all times to bilateral feet every shift, ordered 6/3/24. Wound on bottom of left foot: cleanse with wound cleaner, apply xeroform and bordered dressing. Change one time every other day or as needed if dressing becomes soiled/dislodged, ordered 8/31/24. Protein supplement 30 milliliters (ml) twice daily for wound healing, ordered 8/31/24. Review of Resident #5's treatment administration record (TAR) from 7/1/24 to 9/19/24 revealed staff documented the resident's offloading boots were on every shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-However multiple observations throughout the survey revealed Resident #5's offloading boots were on the dresser while she was in bed or she was only wearing one boot on the left foot while she was sitting in her wheelchair (see observations above). A physician's progress note dated 8/26/24 documented Resident #5 had a new lesion on her foot. The note documented barrier cream, foam and gauze would be applied to the wound and the wound would continue to be monitored. A physician's progress note dated 8/28/24 documentedResident #5 had a new lesion on her foot with no signs of infection. A physician's progress note dated 9/11/24 documented Resident #5's foot wound was not healing very fast. There were no signs of infection and the wound care physician was to follow the wound. A wound progress note dated 8/29/24 documented Resident #5 had an unstageable full thickness skin or tissue loss, depth unknown, pressure ulcer which measured 3.5 centimeters (cm) by 3.5 cm by 0 cm on the left plantar foot surface. The wound was unresolved and was present after admission. A wound progress note dated 9/5/24 documented Resident #5 had an unstageable full thickness skin or tissue loss, depth unknown, pressure ulcer which measured 3.5 cm by 3.5 cm by 0 cm on the left plantar foot surface. The wound was unresolved and was present after admission. A wound tracker form signed by the WCP on 9/12/24 documented Resident #5 had an unstageable full thickness skin or tissue loss, depth unknown, pressure ulcer which measured 3.5 cm by 3.5 cm by 0 cm on the left plantar foot surface. D. Staff interviews RN # 2 was interviewed on 9/19/24 at 12:20 p.m. RN #2 said Resident #5 had a protein supplement and protein shake ordered for wound healing. RN #2 said that Resident #5 wore the offloading boots as ordered, which was all of the time. -However multiple observations throughout the survey revealed Resident #5's offloading boots were on the dresser while she was in bed or she was only wearing one boot on the left foot while she was sitting in her wheelchair (see observations above). Certified nurse aide (CNA) #2 was interviewed on 9/19/24 at 12:24 p.m. CNA #2 said Resident #5 was unable to turn herself in bed. CNA #2 said Resident #5 required two staff members to assist with the hoyer lift to transfer her. CNA #2 said Resident #5 never refused to wear her offloading boots and wore them as ordered. -However multiple observations throughout the survey revealed Resident #5's offloading boots were on the dresser while she was in bed or she was only wearing one boot on the left foot while she was sitting in her wheelchair (see observations above). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The RCR was interviewed on 9/19/24 at 12:54 p.m. The RCR said she was covering for the director of nursing who was absent at the time of the survey. The RCR said a skin assessment was completed upon a resident's admission to the facility. She said the admission nurse completed a skin assessment within 24 hours of admission. The RCR said Resident #5's left foot wound had not been present upon admission to the facility. She said Resident #5 had a moderate risk score for the development of skin breakdown. The RCR said all of the facility mattresses were pressure reducing mattresses. The RCR said Resident #5 had a history of wounds on her feet and the development of the heel wound had been unavoidable. She said Resident #5 had an order to wear offloading boots at all times but the resident refused to wear the boots every night. -However, there was no documentation in Resident #5's electronic medical record (EMR) to indicate the resident refused to wear the offloading boots and staff interviews indicated the resident did not refuse to wear the boots. RN #2 was interviewed again on 9/19/24 at 2:28 p.m. RN #2 said a complete skin assessment was completed on all newly admitted residents. RN #2 said after any skin concern or wound had been assessed, the nurse would call the WCP and fill out a wound tracker sheet. RN #2 said the WCP assessed the left heel wound that Resident #5 developed as an unstageable pressure injury. RN #2 said she did not know how the wound developed because Resident #5 was supposed to wear the off-loading boots at all times. RN #2 said Resident #5 never refused wearing the off-loading boots. RN # 2 said if Resident #5 had refused to wear the boots it would be documented in a nurses note. -An interview was requested with the WCP on 9/19/24, however, the WCP was unavailable for an interview during the survey. IV. Facility follow-up On 9/23/24 (after the survey exit) the facility provided the following information via email: A pressure injury worksheet dated 8/23/24, documented in pertinent part, Wound prevention interventions in place (for Resident #5) were offloading boots, repositioning every two hours, protein supplement, wound care with WCP. The cause of the foot wound was because the resident had been rubbing the bottom of her foot on the foot rest of her wheelchair. The wound was unavoidable related to disease progression, even though interventions were in place. -However, there was no documentation in Resident #5's EMR to indicate turning and repositioning was initiated or being completed, the protein supplement was not ordered until 8/31/24 (seven days after the wound developed), and the WCP did not assess the resident's wound until 8/29/24. -Additionally, multiple observations throughout the survey revealed Resident #5's offloading boots were on the dresser while she was in bed or she was only wearing one boot on the left foot while she was sitting in her wheelchair (see observations above).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on record review, and interviews the facility failed to assist residents in obtaining routine or emergency dental services, as needed for three (#10, #11 and #17) of five residents reviewed for dental services out of 19 sample residents reviewed. Specifically, the facility failed to replace Resident #10, Resident #11 and Resident #17's dentures in a timely manner. Findings include: I. Facility policy and procedure The Dental Services policy and procedure, dated August 2024, was provided by regional clinical resource (RCR) on 9/19/24 at 4:00 p.m. It read in pertinent part, For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days. The resident and/or representative shall be kept informed of all arrangements. II. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physicians order (CPO), diagnoses included dementia and dysphagia (difficulty swallowing). The 7/5/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment indicated the resident had no dental issues or concerns. -However, the resident had missing lower dentures. B. Resident interview Resident #10 was interviewed on 9/16/24 at 11:47 a.m. Resident #10 said her lower set of dentures went missing in February 2024. Resident #10 said she filed a grievance form. Resident #10 said she has not seen a dentist and her dentures had not been replaced. C. Record review A review of Resident #10's comprehensive care plan did not reveal the resident's dental concerns were addressed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A grievance form, dated 2/14/24, was provided by the RCR on 9/18/24 at 9:00 a.m. The grievance form indicated Resident #10 reported her lower dentures were missing on 2/14/24. The grievance said the resident reported the dentures had been missing for one week. The form documented the resident had increased confusion and this may not have been accurate. It indicated the resident was on the list to be seen by a dentist. A request was made for dental visit notes for Resident #10 on 9/17/24. The RCR said the resident had not been seen by the dentist since she submitted a grievance form on 2/14/24 reporting her dentures were missing (see interview below). III. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included unspecified dementia. The 7/19/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The MDS assessment indicated the resident had no dental issues or concerns. -However, the resident was missing her lower dentures. B. Resident interview Resident #11 was interviewed on 9/17/24 at 9:42 a.m. Resident #11 said she had upper and lower dentures upon admission. Resident #11 said she no longer had her bottom set of dentures. Resident #11 said she had not seen a dentist and had not had the lower set replaced. Resident #11 said it changed which foods she chose to eat. C. Record review The nutritional care plan, revised 9/11/23, revealed the resident had missing lower dentures and often chose food she could easily chew with only upper dentures. Pertinent interventions included providing the resident with a dental consult. -However, there was no documentation indicating the resident was seen by the dentist to address her missing dentures. A request was made for dental visit notes for Resident #11 on 9/17/24. The facility did not provide documentation indicating the resident had been seen by the dentist. IV. Resident #17 A. Resident status (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included dysphagia. The 8/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident had no dental issues or concerns. B. Resident interview Resident #17 was interviewed on 9/17/24 at 10:25 a.m. Resident #17 said that her lower dentures were not fitted correctly. Resident #17 said even after she had glued the dentures in, they popped out during meals. Resident #17 said she had been told by the facility that a dentist would be back to look at the fit. Resident #17 said she had not seen a dentist since October 2023. C. Record review A review of the resident's comprehensive care plan did not reveal information regarding the resident's dental status. A dental note, dated 10/5/23, documented an impression was taken with a custom tray. A request was made for dental follow up notes for Resident #17 on 9/17/24. The facility did not provide documentation indicated the resident had been seen by the dentist for follow up. V. Staff interviews Registered nurse (RN) #2 was interviewed on 9/18/24 at 11:49 a.m. RN #2 said if a resident had missing dentures she reported the missing dentures to the social services department. She said the social services director (SSD) would work with the family and the resident to get the dentures replaced. Certified nurse aide (CNA) #1 was interviewed on 9/18/24 at 3:33 p.m. CNA #1 said she was not aware of any residents that had missing dentures. CNA #1 said if a resident reported missing dentures she would look in the trash can and the linen for the dentures. CNA #1 said she would fill out a grievance form and give it to the social services department if the dentures were not found. CNA #2 was interviewed on 9/18/24 at 3:35 p.m. CNA #2 said some residents refused to wear their dentures, but she was not aware of any missing dentures. CNA #2 said if dentures were reported missing she would notify the nurse and the administration. The RCR was interviewed on 9/18/24 at 4:05 p.m. The RCR said if dentures were reported missing, a search should be conducted through the trash and laundry. The RCR said a report should be made by the staff to the social services department. The RCR said the SSD should have followed up with the residents in a timely manner and scheduled dental appointments as needed. The RCR said a resident should have an appointment set within 30 days. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RCR said the grievance for Resident #10 was overdue for a resolution. The RCR said there should be documented interventions while the dentures were missing to include diet accommodations. The RCR said if dentures had become ill-fitting the nursing staff should inspect the mouth for sores, swelling, a cause for the ill-fit. The RCR said the facility should have followed up timely when the residents reported their dentures were missing. The RCR said the SSD should have followed up with an appointment to get the dentures corrected and documentation indicating the steps that were taken. The RCR was interviewed again on 9/19/24 at 9:53 a.m. The RCR said Resident #10 had received a dental appointment on 7/9/24. -However there was no documentation that indicated the resident had a dental appointment on 7/9/24 (see record review above). The RCR said Resident #10 had a new appointment scheduled for 10/7/24. The RCR said she spoke to Resident #17's daughter regarding the ill-fitting dentures. The RCR said Resident #17 had been taken to multiple dentists and there was not anything further to be done about the lower dentures. The RCR said there should have been documentation with interventions, provider assessment, speech assessment and diet evaluation in the resident's electronic medical record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48112 Based on interviews, observations, and record review, the facility failed to consistently serve food that was palatable, attractive, and at the appropriate temperature. Specifically, the facility failed to ensure resident food was palatable in taste, texture and appearance. Findings include: I. Facility policy and procedure The Food Preparation Guidelines policy, revised 4/2024, was provided by the nursing home administrator (NHA) on 9/19/24 at 3:15 p.m. It read in pertinent part, Food should be palatable, attractive, and at a safe and appetizing temperatures. II. Resident group interview A group interview was conducted on 9/18/24 at 10:07 a.m. with five (#11, #17, #31, #35 and #14) residents, who were identified as alert and oriented through facility and assessment. Resident #11, #17, #31 and #35 said the food was not palatable. The residents said the food was overcooked and watery. II. Individual resident interviews Resident #5 interviewed on 9/16/24 at 9:40 a.m. Resident #5 said sometimes the food was overcooked causing her to order take-out. Resident #17 was interviewed on 9/17/24 at 10:25 a.m. Resident #17 said the food was not very good. Resident #17 said the food was served overcooked, dry, or very bland. Resident # 17 was interviewed on 9/18/24 at 10:03 a.m. Resident #17 said the facility needed to serve more fresh fruit. He said he did not like the canned fruit, because it was all the same texture. III. Record review The July 2024 resident council meeting notes were requested. A resident council concern form was provided. It revealed residents wanted more food varieties and consistency. The staff response section revealed the dietary manager (DM) would attend the resident council meetings. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/7/24 resident council meeting notes revealed the residents said the food was awful, there was too much seasoning and the soup was watery. It also documented the residents requested more diabetic dessert options and would like sugar free hot chocolate. The response for more diabetic desserts indicated the DM would look into adding more diabetic desserts to the menu. The DM said there was sugar free hot chocolate, but the residents had to ask for the sugar free hot chocolate. The DM said they would speak to the cooks and come up with suggestions on how to improve the food. The dietary response for the watery soup was the residents would tell the DM when they received watery soup so she could see who was cooking and educate the cook. Resident council notes from 9/4/24 revealed the residents said there was too much pepper in the food, soup was water, roasts too tough, wanted more fresh fruit and sugar free ice cream. The recommendation section said the DMwas notified. The staff response section said the DM would talk to staff about less pepper. The DM said the soup was not too watery because it was soup and not a stew. The DM said she would see if fresh fruit could fit in the budget, would look into sugar free ice cream and residents could buy their own food and keep the food at the nurse's station refrigerator and freezer. IV. Observations During a continuous observation during the lunch meal on 9/18/24, starting at 12:14 p.m. and ending at 1:32 p.m., the following was observed: The bread rolls were in a medium metal container in the food steamer. The rolls in the bottom of the container were sticking together and were smashed. The rolls did not maintain the shape. The lemon and thyme chicken was in a large metal container in the food steamer. The liquid surrounding the chicken was watery. The almond rice pilaf was in a large metal container. The rice on the edges were dark brown. A test tray for a carbohydrate-controlled diet was evaluated by three surveyors immediately after the last resident had been served their meal for lunch on 9/18/24 at 1:40 p.m The menu was grilled chicken breast with lemon and thyme, almond rice pilaf, sugar snap peas, bread or roll and butter, and spiced peaches. The test tray consisted of grilled chicken breast with lemon and thyme, almond rice pilaf, sugar snap peas, roll and spiced peaches. -The chicken was dry and did not taste like there was lemon or thyme; -The almond rice pilaf was bland and did not taste almondy; -Sweet green peas were served instead of the sugar snap peas; -The roll was squished; and, -The spiced peaches tasted like canned peaches with cinnamon. V. Staff interviews (continued on next page)

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	065257	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Storybrook Care & Rehabilitation	1005 E Elizabeth St Fort Collins, CO 80524

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dietary manager (DM) and the NHA were interviewed together on 8/19/24 at 1:50 p.m. The DM said the grilled chicken breast with lemon and thyme should have tasted like there was lemon thyme. She said the chicken should not have been dry. The DM said the almond rice pilaf should have tasted like there was almond in the rice pilaf. The DM said they did not put almonds in the rice pilaf. She said the rolls should not be squished. She said the peas should have been sugar snap peas like the menu indicated. She said it was important for the food to be palatable to reduce complaints and for the residents to have a well-rounded nutrition. The NHA said d he would work the DM to ensure the food was palatable for the residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to provide food that accommodated resident preferences for three (#31, #6, #17) of five residents out of 19 sample residents. Specifically, the facility failed to offer food choices according to resident preferences for Resident #31, #Resident #6 and Resident #17. Findings include: I. Facility policy and procedure The Food Preparation Guidelines policy, revised April 2024, was provided by the nursing home administrator (NHA) on 9/19/24 at 3:15 p.m. It read in pertinent part, Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed. Alternatives shall be appealing and of similar nutritive value to the food that is being substituted. Alternatives shall be consistent with the usual and or ordinary food items provided by the facility. Resident preferences and allergies shall be obtained during the resident assessment process and added to the resident dietary tray card. II. Resident #31 A. Resident status Resident #31, age 69 , was admitted on [DATE]. According to the computerized physician orders (CPO) diagnoses included dementia, psychotic disturbance (a collection of symptoms that causes a loss of reality), mood disturbance and anxiety. The 8/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment indicated the resident was on a therapeutic diet. B. Resident interview Resident #31 was interviewed on 9/18/24 at 10:07 a.m. She said she was a vegetarian. She said there were not enough vegetarian choices for her lunch and dinner meals. She said she ate a lot of grilled cheese sandwiches. Resident #31 said since there were not enough choices she bought her own meal substitutions. She said it really upset her because no one else had to pay for their own meals. She said being a vegetarian was like being a diabetic and the facility should provide her vegetarian options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations On 9/18/24 at 1:03 p.m. cook (CK) #1 preparedResident #31's meal. CK #1 served Resident #31 one serving of peas, one serving of mixed vegetables, one serving of mashed potatoes and one roll. CK #1 said he did not have a vegetarian protein option for the resident. Resident #31's meal ticket indicated she was on a vegetarian diet. D. Record review The nutrition care plan, revised 3/20/24, revealed the resident followed a lacto-ovo vegetarian diet (vegetarian diet that includes dairy and eggs) and complained about the limited food choices. Interventions included providing the resident her diet as ordered, honoring food preferences and educating the resident on the variety of menu options available for preferences. The 9/4/24 quarterly dietary assessments revealed the resident was prescribed a vegetarian diet. E. Staff interview The dietary manager (DM) and the NHA were interviewed together on 9/19/24 at 1:50 p.m. The DM said she was responsible for obtaining the resident's preference. She said she reviewed the resident's food preferences at admission, quarterly and as needed. She said she documented the preferences on a paper form kept in her office. The DM said preferences were added to the meal tickets. She said the cooks were aware of the resident's food preferences, because they were documented on the meal ticket. The DM said Resident #31 was vegetarian. She said the facility provided vegetarian protein options such as tofu and meatless chicken patties. The DM said the cook did not provide a vegetarian protein because it was an oversight. She said the facility changed how to order food from their supplier and she was limited in choices for vegetarian proteins. The NHA said he would work with the DM to have more choice for vegetarian proteins. 51160 III. Resident #17 A. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included diabetes mellitus and dysphagia (difficulty swallowing). The 8/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. B. Resident interview Resident #17 was interviewed on 9/17/24 at 10:25 a.m. Resident #17 said the facility needed more diabetic desserts than just jello. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 17 was interviewed again on 9/18/24 at 10:03 a.m. Resident #17 said she would prefer to have more fresh fruit options. She said the facility only served canned fruit. IV. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnosis included diabetes mellitus. The 8/29/24 MDS assessment revealed the resident had moderately impaired cognition with a BIMS score of 10 out of 15. B. Resident interview Resident # 6 was interviewed on 9/18/24 at 5:20 p.m. Resident #6 said the facility had not been diabetic friendly. Resident #6 said the majority of the menu was carbohydrate heavy such as pancakes, waffles, potatoes, and corn. Resident # 6 said she had been struggling with her blood glucose levels being in the 500-600 range. Resident # 6 said she believed it was from the hidden additives and sugars in the food, for example canned fruit in syrup. Resident #6 said, even though the can of fruit may have said no added sugar, it is canned fruit, it is still full of sugar. Resident #6 said the only dessert and snack options available for diabetic residents were sugar-free jello, and sugar-free vanilla pudding. C. Record review The August 2024 resident council meeting notes were provided on 9/18/24 at 9:00 a.m. Resident Council Meeting notes dated August 2024 were provided by the regional clinical nurse resource (RCR). The council meeting notes documentedResident #6 requested more diabetic dessert options. The current diabetic dessert options are sugar-free jello and pudding. D. Staff interviews Registered nurse (RN) #2 was interviewed on 9/18/24 at 11:49 a.m. RN #2 said the dietary staff were responsible for stocking the refrigerator at the nurses station with sandwiches, pudding, crackers and cheese and string cheese. RN #2 said the facility had sugar-free jello and sugar-free pudding available for the diabetic residents. Certified nurse aide (CNA) #2 was interviewed on 9/18/24 at 3:35 p.m. CNA #2 said snacks were available in the nurse's station. CNA #2 said the diabetic residents could have sugar-free pudding. The DM was interviewed on 9/19/24 at 1:25 p.m. The DM said the facility would be working towards getting additional diabetic dessert/snack choices other than sugar-free jello and pudding. The DM said the only options the facility currently had to offer the diabetic residents were sugar-free jello and pudding.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure food was labeled and dated appropriately; -Ensure food stored at least six inches above the floor; -Ensure to ensure the kitchen equipment was clean; and, -Ensure staff completed hand hygiene appropriately in the dining room. Findings include: I. Failed to ensure food was labeled and dated A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, was retrieved on 10/1/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view It read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. B. Observations On 9/16/24 at 8:42 a.m. during the initial kitchen tour, there were three plastic dispensing containers in the main dining room. The containers held three different types of breakfast cereal. The first container was labeled Cheerios and the label indicated the Cheerios were prepared 4/1, and to use by 5/1. The second container contained Raisin Bran, the container did not have a label or a date. The third container was labeled Rice Krispies and was labeled 6/7. The Rice Krispies label did not indicate if the date was the open date or the use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Staff interview The dietary manager (DM) was interviewed on 9/16/24 at 8:47 a.m. The DM said the cereal container without a label should have been labeled with what the cereal was, when it was prepared and when it should be discarded. She said the Cheerios and the Rice Krispies cereal should have been discarded by the use by date. The DM said when food was removed from the original packaging the food should be labeled with the food name, when the food was opened and when the food should be discarded. II. Failed to ensure food was stored at least six inches above the floor A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, was retrieved on 10/1/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, Food shall be protected from contamination by storing the food in a clean, dry location; where it is not exposed to splash, dust, or other contamination and at least 15 centimeters (six inches) above the floor. B. Observations On 9/16/24 at 8:42 a.m. during the initial kitchen tour, there was a large box of individual bags of chips on the middle of the ground in the dry storage. There was a box that contained two large bottles of vinegar on thee ground in the dry storage. There were two boxes of soda on the ground in the dry storage. C. Staff interview The DM was interviewed on 9/16/24 at 8:47 a.m. The DM said the staff knew to keep food six inches off the ground in the panty. She said she would talk to her staff to remove the items from the floor. The DM said the kitchen was small and made it difficult to store food. III. Failed to ensure kitchen equipment was clean A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, was retrieved on 10/1/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, Equipment food contact surfaces and utensils shall be clean to sight and touch. B. Observations and interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at 8:42 a.m. during the initial kitchen tour, the commercial mixer was in the corner of a counter in the kitchen and not in use. The mixing device and the mixer attachment was covered with dry, dark brown food. The DM said the mixer was last used to make chocolate cake more than a week ago and the mixer should have been cleaned after use. On 9/18/24 at 1:04 p.m. during lunch meal service, the commercial mixer was in the corner of a counter in the kitchen. The mixer and the mixer attachement was covered with dry, dark brown food. C. Staff interview The DM was interviewed on 9/19/24 at 1:50 p.m. The DM said she did not know the mixer was not cleaned after use. The DM said the mixer should have been cleaned after she identified it was dirty on 9/16/24. She said the mixer should be free from food debris after use and prior to storage. 51160 IV. Failure to ensure staff performed appropriate hand hygiene and glove usage in the dining room A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved from: https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. It read in pertinent part, Single-use gloves shall be used for only one task, such as working with ready-to-eat food, or with raw animal food. Single-use gloves shall be used for no other purpose, and discarded when damaged, when interruptions occur in the operation, or when the task is completed. The Centers for Disease Control and Prevention (CDC) (2024), Clinical Safety: Hand Hygiene for Healthcare Workers, was retrieved on 9/9/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part, Perform hand hygiene before touching a patient, after touching a patient or their surroundings, immediately after glove removal. According to Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022.) Basic Nursing: Thinking, Doing and Caring, (Third edition), pages 1601, 1604-1605, Use standard precautions to prevent the transmission of infection. Implement measures to prevent healthcare-associated infections (HAIs). HAIs are the leading complication of healthcare and one of the ten leading causes of death in the United States. Hand hygiene can remove transient flora (microbes acquired by touching objects or people). B. Observations During a continuous observation on 9/16/24, beginning at 7:50 a.m. and ending at 8:45 a.m., the following was observed in the main dining room: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:00 a.m., prior to the meal being served, the floor of the dining room was observed to have food crumbs and various debris on the floor such as straw and food wrappers. At 8:11 a.m. dietary aide (DA) #1 donned (put on) a pair of gloves and assembled resident meal trays as items were passed to him through the kitchen pass. At 8:14 a.m. DA #1 delivered a meal tray to a resident, with the same gloved hands he readjusted her wheelchair touching the handles, then returned to get the next tray. DA #1 delivered the remaining resident meal trays without changing gloves or performing hand hygiene. At 8:23 a.m. with the same gloved hands, DA #1 provided coffee refills to residents without changing gloves or performing hand hygiene. At 8:26 a.m. with the same gloves hands, DA #1 delivered a cart of meal trays to the main hallway without changing gloves or performing hand hygiene. Each resident tray was delivered, then each bowl, dish or cup was removed from the tray and placed in front of the resident with the lids or covers being removed. During a continuous observation on 9/16/24, beginning at 12:25 p.m. and ending at 1:45 p.m., the following was observed in the main dining room. At 12:28 p.m. DA #1 delivered a cart of meal trays to the main hallway wearing the same pair of gloves. At 12:30 p.m. DA #1 returned to the dining room and began to assemble resident meal trays as items were handed to him through the kitchen pass without changing gloves or performing hand hygiene. At 12:33 p.m. Resident #21 came into the dining room requesting ice to be refilled in her personal cup. Without removing his gloves, DA #1 opened the cup touching the mouthpiece, refilled it with ice, secured the lid and handed it back to Resident #21. DA #1 returned to the kitchen pass and resumed assembling meal trays without changing gloves or performing hand hygiene. At 12:36 p.m. DA #1 delivered a cart of resident meal trays to the main hallway with the same gloved hands . At 12:38 p.m. DA #1 returned to the dining room and proceeded to deliver the dining room meals trays with the same gloved hands. At 12:48 p.m. an unidentified CNA providing feeding assistance to a resident got up and walked across the room to provide assistance to another resident with their utensils without performing hand hygiene, then returned to the previous resident and continued feeding assistance without performing hand hygiene. At 1:00 p.m. the same staff member, walked to another resident, provided assistance by changing the position of food dishes and handing the resident a utensil that had been dropped on the table trying to eat from a dish that had been out of reach without performing hand hygiene, then returned to provide feeding assistance to the first resident without performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 9/17/24, beginning at 12:00 p.m. and ending at 1:30 p.m., the following was observed in the main dining roo:. At 12:23 p.m. DA #2 picked up a soiled napkin from the floor, without performing hand hygiene, DA #2 then continued to serve resident's their meals until 12:31 p.m., when DA #2 assisted a resident to refill their personal cup with ice. With the same gloves hands DA #2 opened the cup, touching the mouth piece, filled the cup with ice, then secured the lid without performing hand hygiene. DA #2 then continued to serve residents lunch trays, opened and adjusted their food placement on the table without performing hand hygiene in between residents. C. Staff interviews The regional clinical resource (RCR) was interviewed on 9/19/24 at 11:31 a.m. The RCR said she was covering for the infection preventionist (IP) who was on vacation at the time of the survey. The RCR said that the DAs should be touching only the outer edges of trays, plates and performing hand hygiene in between providing assistance for residents. The RCR said staff should be washing hands in between, residents and touching surfaces. The RCR said if a staff member ws wearing gloves, the gloves should be changed before a residents meal tray for set up and in between tasks that would be considered clean or dirty.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51160 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the laundry room was free from environmental concerns. Findings include: I. Observations On 9/18/24 at 4:48 p.m. the laundry area was observed. There were multiple clean resident hoyer slings hanging in the dirty laundry room with their straps touching the ground. The hoyer slings were also hanging next to a mop bucket with the outermost sling touching the bucket. The ceiling above the washing machines had been damaged with peeling paint above where clean laundry would be removed from the machines. On the floor next to the slings were clean, folded blankets that had been partially bagged in black trash bags. The door between the clean and dirty laundry rooms was unable to be closed due to a shift in the door frame. II. Staff interviews The regional clinical resource (RCR) was interviewed on 9/19/24 at 11:31 a.m. The RCR said there had been a recent leak in the laundry room and there should be repairs made to the ceiling. The director of housekeeping (DH) was interviewed on 9/19/24 at 12:40 p.m. The DH said the staff members retrieved clean slings from the soiled utility room where they were hung during observation. The DH said he did not know that the placement of the clean slings in the laundry room would cause them to become dirty. The DH said the cleaned, folded blankets would be moved to a clean location. The DH said the facility needed to order a fire door to replace the door between the clean and dirty. The DH said that he was new to the role, as was the maintenance director and they had been playing catch up with needs in the facility.