STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065258	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizons Care Center	11411 Highway 65 Eckert, CO 81418

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 40467

Based on observations, interviews and record review, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#9) of one out of 20 sample residents.

Specifically, the facility failed to appropriately assess Resident #9 for self-administration of medications.

Findings include:

I. Professional reference

According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 2016, was retrieved on 11/12/24, Do not leave medications at the bedside. If you leave the medication on the bedside table, how do you know they took the medication? Someone else could come in and take or discard the medication.

II. Facility policy and procedure

The General Dose Preparation and Medication Administration policy, undated, was provided by the nursing home administrator (NHA) on 11/7/24 at 1:47 p.m. It documented in pertinent part,

Facility staff should not leave medications or chemicals unattended.

III. Resident #9

A. Resident status

Resident #9, age greater than age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included gastroesophageal reflux disease with esophagitis without bleeding, acquired absence of other specified parts of digestive tract, personal history of transient ischemic attack (TIA), cerebral infarction with without residual deficits, personal history of malignant neoplasm of other organs and systems, dysphagia oropharyngeal phase (difficulty swallowing), muscle weakness and reduced mobility.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/15/24 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 resident did not have limited range in motion with his upper or lower extremities. According to the assessment, the resident had rejection of care behavioral symptoms. B. Observation and interview On 11/6/24 at 1:27 p.m. a single white tablet in a medication administration cup was observed next to the resident's meal tray. The resident said the medication was for his stomach. He said the nurse would usually leave his Zofran on his table so he could take it when he was ready. C. Record review The sleep care plan, revised 3/12/24, identified Resident #9 was at risk for altered sleep. According to the care plan, the resident slept less than normal requirements. The resident's goal was to have a restful sleep. -The care plan did not identify that the resident did not want to be woken up for medication administration. -The care plan did not direct staff what to do if the resident was asleep during his medication pass. The fall care plan related safety, revised on 11/7/24, documented Resident #9 desired to have medication left at his bedside for the resident to self administer. According to the careplan, the IDT felt it was unsafe for his medication to be left at bedside. The 11/7/24 care plan investigation directed staff not to leave medication at the resident's bedside. -Review of the comprehensive care plan did not indicate the resident was able to self-administer medications. A review of Resident #9's November 2024 CPO revealed a physician's order for Zofran, directed staff to administer four milligrams (mg) of Zofran in oral tablet form before meals and at bedtime for nausea and vomiting, ordered on 8/13/24. -The review of the CPO did not identify Resident #9 had a physician's order to self administer his medication. The November 2024 medication administration record (MAR) documented Resident #9 received Zofran four times a day. According to the MAR, the resident received the Zofran daily at 7:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An on the spot training for medications was provided on 11/7/24 by the corporate consultant (CC). The training was conducted on 11/7/24 (see interviews below) during the survey period. The training read, Medication should not be left for the resident to take without supervision. If a resident voiced the desire to do self-administration, the IDT (interdisciplinary) team must meet to see if it is safe. If this is the route then the IDT team will get physicians to allow the resident to self-administer the medication. Do not leave medications on the bedside table. A 11/7/24 self-administeration of medications assessment was provided by the facility on 11/7/24 at approximately 5:45 p.m. The assessment was conducted during the survey period (see interviews below). The assessment identified Resident #9 wished to self administer medications or have them kept at bedside. According to the assessment, the resident sleeping patterns and timeliness of medication administration could be at a risk. The resident was deemed unsafe to self administer his medications. -The review of Resident #9's electronic medical record (EMR) did not reveal the resident had a self-administration assessment prior to 11/7/24. A 11/7/24 progress note documented the interdisciplinary team (IDT) met and discussed self-administration of medication for Resident #9. According to the note, the IDT felt the resident would not be safe for self medicating due to often falling asleep and not taking his medication timely. The note revealed it would be a risk for staff to leave the resident's medication at his bedside. D. Staff interview Registered nurse (RN) #2 was interviewed on 11/6/24 at 1:36 p.m. RN #2 said she tried to wake up residents if they were asleep when she was administering their medications. She said Resident #9 did not want to be woken up before meals to take his Zofran and would get upset. She said sometimes she would drop off the Zofran in his room if he was asleep. She said she left the Zofran tablet in his room at 12:30 p.m. so he could take it when he woke up. She said Resident #9 did not have a medication self administration order from the physician. RN #2 was interviewed again on 11/7/24 at 10:10 a.m. RN #2 said all physician's orders should be followed. She said she had not reached out to the physician to determine if Resident #9 would be appropriate for a medication self administered order. She said this morning (11/7/24) she made sure Resident #9 was awake before she gave him his Zofran and made sure he took it. She said residents should have a self administration order if they were not supervised for medication administration. RN #2 said Resident #9 would probably not be appropriate for a medication self administration order because he was sometimes confused and tired and may not administer the medication timely. She said Resident #9 liked to do things on his own time. (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) was interviewed on 11/7/24 at 11:45 a.m. The DON said all medications should be stored in the medication cart until the nurse administers the medication. The DON said medication administration should be supervised by the nurse unless the resident had an order to self administer. She said Resident #9 did not have an order to self administer his medication and RN #2 should not have left Zofran alone in his room for him to take when he woke up. She said there were currently no residents that would wander in his room and take the medication but it was still a risk if left out. She said Resident #9 could be evaluated for self administration but it would be questionable if he would be appropriate. The DON said RN #2 would be re-education on medication administration on 11/7/24. She said would discuss a plan with Resident #9 and the physician so Resident #9 could receive his medication supervised and timely.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure resident choices for one (#18) of five residents reviewed for activities of daily living (ADL) out of 20 sample residents. Specifically, the facility failed to provide bathing assistance for Resident #18 per his preference. Findings include: I. Facility policy and procedure The Showers, Bed Bath and Tub Bath policy, revised March 2012, was received from the corporate consultant (CC) on 11/7/24 at 1:11 p.m. It documented in pertinent part, The facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes ensuring that the facility provides care and services for the following activities of daily living: hygiene - bathing. II. Resident #18 A. Resident status Resident #18, over the age of 65, was admitted on [DATE]. According to the November 2024 computerized physician order (CPO), diagnoses included neoplasm of the brain (cancer of the brain), chronic respiratory failure and unspecified dementia. According to the 9/20/24 minimum data set (MDS) assessment Resident #18 was intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment documented Resident #18 required moderate assistance with tub/shower transfers. The assessment documented the resident had no rejections of care. B. Resident interview Resident #18 was interviewed on 11/4/24 at 3:14 p.m. Resident #18 said he wanted to receive two showers per week, but that often did not happen. Resident #18 said he typically received one shower per week. He said he had gone a week of time without being offered a shower. Resident #18 said he felt ignored when the nursing staff did not offer him showers regularly. III. Record review The ADL plan of care, initiated on 6/24/24 and revised on 7/12/24, revealed Resident #18 required one person assistance with bathing. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Bathing/shower preference documentation, dated 6/24/24, documented Resident #18 requested two baths per week in the mid-morning. The facility point of care bathing documentation was reviewed for 30 days (10/6/24 and 11/6/24). In the 30 day review period, Resident #18 was documented to have received three baths out of eight opportunities for bathing. It revealed Resident #18 had refused two baths and was not available for one bath offered in the review period. -However, a review of the electronic medical record (EMR) did not document a reason for bathing refusals by Resident #18. Resident #18's EMR did not include documentation of bathing being re-offered to the resident after the resident refused bathing. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 11/6/24 at 4:11 p.m. CNA #1 said the residents typically received two baths per week unless they requested a different schedule. CNA #1 said if a resident refused a bath, the nurse should be notified and the bath should be re-offered that week. CNA #1 said the staffing at the facility had been much better recently since the facility census had been less than in recent months. CNA #1 said baths were documented electronically in the electronic medical record (EMR). Registered nurse (RN) #1 was interviewed on 11/7/24 at 10:24 a.m. RN #1 said the residents received two baths per week on specific days unless the resident had a more specific preference. RN #1 said baths should be re-offered to residents the same day if the resident refused. The director of nursing (DON) was interviewed on 11/7/24 at 3:42 p.m. The DON said she reviewed Resident #18's bathing documentation between 10/6/24 and 11/6/24. The DON said Resident #18 did not receive enough baths. The DON said the residents should receive two baths per week or by their stated preference. The DON said the nursing staff should investigate the reason why a resident would refuse their bath. The DON said the refused bath should be re-offered to the resident when they would prefer to have it. The DON said the facility documented all bathing offered electronically.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations and interviews, the facility failed to maintain a comfortable homelike environment for residents on one of four units. Specifically, the facility failed to ensure the 400 hallway maintained a temperature of 71 degrees fahrenheit (F) to 81 degrees F. Findings include: I. Facility policy and procedure The Safe Physical Environment policy, revised May 2023, was received from the director of nursing (DON) on 11/7/24 at 1:43 p.m. The policy documented that safe and comfortable temperatures were maintained in the facility. II. Resident interviews One of the residents who resided in room [ROOM NUMBER], who was cognitively intact, was interviewed on 11/4/24 at 3:11 p.m. The resident said his room felt very cold in the morning. He said he had to turn up the thermostat in his room to 78 degrees and close the door to make his room temperature comfortable. The second resident who resided in room [ROOM NUMBER], who was cognitively intact, was interviewed on 11/4/24 at 3:14 p.m. The resident said his room was very cold throughout the day, but mostly in the mornings. He said there was a cold draft outside of his room that he had to consider when choosing clothing or setting the room temperature. He said he felt frustrated that he had to change the temperature of his room several times throughout the day. III. Observations On 11/5/24 at 9:08 a.m., a cold draft was noted in the hallway outside of room [ROOM NUMBER]. The temperature outside room [ROOM NUMBER] read 56.8 degrees F. On 11/6/24 at 8:52 a.m., a cold draft was noted in the hallway outside of room [ROOM NUMBER] a second time. The temperature outside room [ROOM NUMBER] read 58.1 degrees F. On 11/7/24, there was not a cold draft noted in the hallway outside of room [ROOM NUMBER]. However, when a temperature reading of the area in the hallway outside of room [ROOM NUMBER] was obtained, the temperature read 70.2 degrees F. -The temperature reading in the hallway outside of room [ROOM NUMBER] on three consecutive days was below the comfortable and safe temperature level of 71 degrees F to 81 degrees F. IV. Staff interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper (HSKP) #1 was interviewed on 11/5/24 at 9:14 a.m. HSKP #1 said the cold draft on the 400 hall occurred because the facility had not placed covers over the vents in the ceiling outside of room [ROOM NUMBER]. HSKP #1 said the maintenance department was supposed to cover the ceiling vents in the wintertime. HSKP #1 said she did not know why the vents had not been covered yet since the outside temperatures had already dropped below freezing recently. The maintenance director (MTD) was interviewed on 11/7/24 at 10:02 a.m. The MTD said the ceiling vent on the 400 hall had not been covered from 11/4/24 to 11/6/24, when the temperature readings were obtained outside of room [ROOM NUMBER]. The MTD said the vent was covered by the maintenance assistant on the morning of 11/7/24 (during the survey). The MTD said he did not know what the appropriate temperature should be for the 400 hallway. The MTD said 56 degrees F was not an appropriate temperature for residents on a hallway because it was too cold. The DON was interviewed on 11/7/24 at 3:42 p.m. The DON said she was not aware a ceiling vent was open on the 400 hallway and was blowing cold air. The DON said she did not know what temperature was appropriate for the facility to maintain, but the temperature should be comfortable for residents. The DON said 56 degrees F was not acceptable for a hallway temperature and was too cold.

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to provide services by qualified persons for two (#14 and #30) of three residents reviewed for falls out of 20 sample residents. Specifically, the facility failed to ensure Resident #14 and Resident #30 were assessed by a registered nurse (RN) after sustaining unwitnessed falls. Findings include: I. Facility policy and procedure The Fall Management Program policy, undated, was provided by the nursing home administrator (NHA) on 11/7/24 at 3:41 p.m. It documented in pertinent part, All staff are trained on falls. If you are not a nurse and discover a resident has fallen - immediately have someone get a nurse to help assess/collect data while you stay with the resident. II. Resident #14 A. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included blindness, right and left leg amputations and generalized muscle weakness. The 9/25/24 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 resident required moderate assistance with showering and dressing, was dependent on nursing care for shower transferring, and required set-up or cleanup assistance with eating and oral hygiene. B. Record review A Morse Fall Scale assessment, dated 1/12/24, documented Resident #14 was a low risk for falls. A neurological check assessment flow sheet for Resident #14 was provided by the nursing home administrator (NHA) on 11/6/24 at 11:14 a.m. It documented Resident #14 received neurological assessments starting at 7:15 a.m. on 1/13/24 through the evening shift of 1/15/24. -All documented assessments were completed by a licensed practical nurse (LPN) instead of a RN. Post-incident review documentation, dated 1/13/24, was provided by the NHA on 11/6/24 at 11:14 a.m. The documentation revealed that Resident #14 had an unwitnessed fall on 1/13/24 and was found laying on the floor between the bed and the wall with blood present on the back of his head. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documentation indicated Resident #14 fell because he was legally blind and did not have an assistive device attached to his bed as he did at home to assist in orienting the resident to where the bed was in relation to the room. The facility documented Resident #14 was offered to be evaluated in the emergency room which Resident #14 declined. -The documentation was signed by LPNs and did not contain a signature from a RN to indicate a RN had assessed Resident #14 following his fall. A nursing note dated 1/14/24 documented that Resident #14 denied pain on the back of his head after his fall. The note documented that Resident #14 had a bruise and skin tear on the back of his head. A nursing progress note dated 1/20/24 documented Resident #14 complained of additional pain to the back of his head and neck. The nursing note documented Resident #14 said this headache had existed for a few days and was getting progressively worse. The note documented the nurse informed the physician who recommended Resident #14 be evaluated in the emergency room . A final post-incident review, dated 1/22/24, documented Resident #14 developed additional neck pain on 1/20/24 which was not resolved by his ordered as-needed pain medication. The review documented that Resident #14 was sent to the emergency roiagnom on [DATE]. The review documented Resident #14 was diagnosed with a T-2 compression fracture and was returned to the facility on [DATE] with an additional prescription for pain medication. III. Resident #30 A. Resident status Resident #30, age greater than age 65, was admitted on [DATE] and passed away at the facility on 8/28/24. According to the August 2024 CPO, diagnoses included morbid obesity due to excess calories, chronic diastolic (congestive heart failure), pulmonary hypertension, hypertensive heart disease with heart failure and paroxysmal atrial fibrillation. The 8/15/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident did not have inattention or disoriented thinking. The resident required minimal assistance with her activities of daily living (ADL). According to the MDS assessment, the resident had not had a fall since admission. The assessment did not identify if the resident had a history of falls prior to admission. B. Record review The 8/9/24 fall risk summary note indicated Resident #30 had a Morse Fall Scale assessment completed. According to the note, the resident had a moderate risk for falling. The 8/28/24 post-incident note revealed Resident #30 had an unwitnessed fall at 6:00 a.m. According to the note, the resident was evaluated for injuries, the physician was notified and the appropriate staff was notified. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/28/24 neurological check assessment flow sheet was provided by the director of nursing (DON) on 11/7/24 at 2:04 p.m. The neurological check assessment flow sheet identified the resident was checked as scheduled. She was alert, with normal motor and sensory function. Her pupils were reactive to the light with brisk movement. The resident had pulse and blood pressure fluctuations. The assessment was completed at 6:20 a.m., 6:35 a.m., 7:35 a.m., 8:35 a.m. and 10:35 a.m. -The neurological check assessment flow sheet was signed by LPN #2 instead of a RN. The 8/28/24 at 6:20 a.m. post-incident review assessment was provided by the DON on 11/7/24 at 2:04 p.m. -The post-incident review assessment was completed and signed by LPN #2 instead of a RN. According to the assessment, the resident was found on the floor in her room. Resident #30 said was trying to walk to the bathroom. The resident did not have injuries as a result of the fall. The post-incident review documented the NHA and the DON were notified of the resident's fall at 7:00 a.m. -The DON, who was a RN, was not notified until an hour after Resident #30's fall. An 8/28/24 at 10:47 a.m. nursing note documented a RN assessed the resident after her fall on the morning of 8/28/24 and educated the resident on the need to be evaluated by her physician or the emergency room at the hospital. -However, according to the documentation provided by the facility (see above), LPN #2 initially performed the assessment on Resident #30 at the time of the fall on 8/28/24 at 6:00 a.m. The nursing note which indicated a RN assessed the resident was not documented until 10:47 a.m. on 8/28/24, over four hours after the resident's fall. IV. Staff interviews LPN #2 was interviewed on 11/5/24 at 9:09 a.m. LPN #2 said LPNs were not allowed to perform assessments on residents after a fall. LPN #2 said a RN must perform a post-fall assessment after a resident fell . Certified nursing aide (CNA) #1 was interviewed on 11/6/24 at 4:11 p.m. CNA #1 said if a resident fell , she would get a nurse right away to make sure the resident was okay. CNA #1 said she thought a RN had to perform a resident assessment after a fall because LPNs were not allowed to. RN #1 was interviewed on 11/7/24 at 10:24 a.m. RN #1 said a RN must perform all assessments on residents after a fall. RN #1 said LPNs were not able to perform assessments because it was outside of their scope of practice. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 11/7/24 at 12:34 p.m. The DON said she got a call by the night shift nurse that Resident #30 had an unwitnessed fall when she walked with her walker to the bathroom and her legs became weak. The DON said she was informed the resident was last seen approximately 15 to 30 minutes before she fell . The DON said the resident was able to ambulate with her walker independently but had not felt well and had emesis (vomiting) the night before. The DON said the resident informed the staff she did not hit her head, but because the fall was unwitnessed, a neurological assessment was conducted. The DON was interviewed a second time on 11/7/24 at 3:42 p.m. The DON said post-fall assessments must be completed by RNs because assessing residents was not in a LPNs scope of practice. The DON said she had reviewed post-fall documentation for Resident #14 on 1/12/24. The DON said the assessment documentation for Resident #14's fall was completed by LPNs. The DON said LPNs were allowed to gather information for RNs to interpret for an assessment, however, she said there was no documentation of a RN completing an assessment for Resident #14. The DON and the nursing home administrator (NHA) were interviewed together on 11/7/24 at 4:18 p.m. The DON said a LPN could gather data after a fall but a RN needed to be the one to assess the resident. The DON said LPNs did not have the scope of practice to assess a resident after a fall, but the facility did not have a RN on duty at the facility 24 hours a day. She said a resident should be immediately assessed after a fall. The DON said there was no documentation identifying a RN assessed Resident #14 after he fell in January 2024. She said if a resident fell at night, a resident would not be assessed by a RN. She said if staff had questions, they could call her and she could come in. The DON said she lived five minutes from the facility but she was not available to come in when Resident #14 fell . The NHA said a RN had to assess a resident after a fall. She said a LPN could call the RN and review all the information with the RN. The NHA said it was the facility's policy to contact the NHA, the DON or the assistant director of nursing (ADON) after a fall. The DON said she did not document she was notified right after Resident #30 fell . She said she did not think her documentation would matter. The DON said a RN assessment after a fall would include assessing the resident's grasp, pupils, vital signs, skin, range of motion, pain, mobility, change in speech and cognition. The DON said LPN #2 was the nurse who assessed Resident #30 after she was found on the floor at 6:00 a. m. The DON said LPN #2 put eyes on the resident after she fell and thought that was enough. The DON said she looked at all of the staff documentation related to the resident's fall and was able to piece together what happened. She said Resident #30 was not injured after the fall but she had a severe cardiac history. She said the physician was notified the resident was not feeling well and she was encouraged to go to the hospital after the fall. The DON said the resident declined going to the hospital and said she was just tired. 40467

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Horizons Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11411 Highway 65 Eckert, CO 81418	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure two (#11 and#18) of five residents reviewed for activities of daily living (ADLs) received appropriate treatment and services to maintain or improve his or her abilities out of 20 sample residents. Specifically, the facility failed to provide the necessary assistance and equipment for Resident #11 and Resident #18, who required assistance and encouragement with eating. Findings include: I. Facility policy and procedure The Long-term care feeding policy, revised 12/11/23, was obtained from the corporate consultant (CC) on 11/7/24 at 3:41 p.m. It documented in pertinent part, Various disabilities and conditions may prevent a resident from self-feeding, including cognitive deficits, neuromuscular disease, cancer, obstructive lung disease, and traumatic injury. A resident who cannot self-feed is susceptible to malnutrition. The resident may also experience pain, nausea, depression, and anorexia as a result of the condition or its associated treatment. Meeting such a resident's nutritional needs requires determining food preferences; feeding the resident in a friendly, unhurried manner; encouraging self-feeding to promote independence and dignity; and documenting intake and output. Allow the resident control over mealtime, such as by letting the resident set the pace of the meal or decide the order in which to eat various foods because many adults consider being fed demeaning. Introduce adaptive feeding devices before mealtime, with the resident seated in a natural position. Explain and reinforce the purpose of the device, show the resident how to use it, and encourage practice. Encourage the resident to indicate readiness for another mouthful. Pause between courses and whenever the resident wants to rest. The Dining Experience: Staff Responsibilities policy, revised 2023, was provided by the CC on 11/7/24 at 4:31 p.m. It read in pertinent part, Staff will treat each individual with dignity and respect and strive to meet their personal needs. During meals staff will socialize with, listen, pay attention and converse with each individual. Staff should offer as many choices as possible when it comes to meal times: choices of what to eat, when to eat and who to eat with. Support staff work under the supervision of the registered dietitian. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff will offer assistance as needed in order to maintain, improve and/or prevent a decline in eating ability. The Person-Centered Dining Approach policy, revised 2023, was provided by the CC on 11/7/24 at 4:31 p.m. It documented in pertinent part, Food and beverage preferences and special dietary needs should be met based on individual choice and/or physician's order. Individuals will be provided with the proper assistive devices and utensils identified by the care plan. Staff will provide support with assistive devices as needed. Staff will provide cueing, prompting or assistance as needed in order to maintain, improve and prevent decline in eating ability. II. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included unspecified severe dementia with psychological disturbance, dysphagia (difficulty swallowing) and Alzheimer's disease. The 10/8/24 minimum data set (MDS) assessment revealed the resident was rarely or never understood and could not complete the brief interview for mental status (BIMS) assessment. He was dependent on nursing staff for all cares and activities of daily living (ADL). The assessment documented Resident #11 was severely cognitively impaired and rarely or never made daily decisions. The assessment documented Resident #11 continuously presented with inattention, disorganized thinking, and an altered level of consciousness. The assessment documented Resident #11 had no rejections of care. B. Observations During a continuous observation in the dining room on 11/4/24, beginning at 11:27 a.m. and ending at 12:42 p.m., the following was observed: At 11:47 a.m. Resident #11 was assisted to the dining room at 11:47 a.m. Resident #11 was assisted with his meal from 11:53 a.m. to 12:09 p.m. by certified nurse aide (CNA) #3. At 12:09 p.m. CNA #3 stopped assisting Resident #11 and began assisting an unidentified resident who was sitting across the table from Resident #11. Resident #11 was without assistance in the dining hall between 12:09 p.m and 12:21 p.m. At 12:21 p.m. CNA #3 was observed to tell CNA #1 that Resident #11 was done eating and was ready to return to his room. At 12:22, CNA #1 was observed to remove Resident #11's clothing protector and assisted the resident out of the dining hall. Resident #11 was observed to eat less than 25% of this meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA #1 and CNA #3 did not offer Resident #11 extra time for meal assistance as identified in his nutritional plan of care (see below). -CNA #1 and CNA #3 did not offer Resident #11 an alternative meal option after he consumed less than 25% of the meal. During a continuous observation in the dining room on 11/6/24, beginning at 11:22 a.m. and ending at 12:57 p.m., the following was observed: At 11:48 a.m. the director of nursing (DON) was observed to sit by Resident #11 and assist him to drink fluids. At 11:49 a.m., the DON was observed to leave Resident #11 and go into the kitchen. At 12:01 p.m. CNA #3 was observed to place gloves on the dining table in front of Resident #11 but did not offer assistance consuming his beverage. At 12:18 p.m., CNA #3 was observed to sit next to Resident #11 and offer meal assistance to consume his beverage. At 12:19, CNA #3 was observed to leave Resident #11 alone and assist other residents in the dining hall. Resident #11 was without meal assistance between 12:19 p.m. and 12:24 p.m. At 12:24 p.m. CNA #1 was observed to sit next to Resident #11 and offer meal assistance drinking his beverage which Resident #11 accepted. CNA #1 was not observed to offer meal assistance to Resident #11 between 12:24 p.m. and 12:36 p.m. At 12:36 p.m. CNA #1 offered Resident #11 meal assistance drinking his beverage. At 12:37 p.m. CNA #1 was then observed to leave Resident #11 alone in the dining hall and assist other residents in the dining hall. Resident #11 was without meal assistance between 12:37 p.m. and 12:48 p.m. Resident #11's food was delivered to him at 12:48 p.m. At 12:49 p.m. CNA #1 returned to sit next to Resident #11 and offered food assistance. At 12:51 p.m. Resident #11's representative arrived in the dining hall for a visit. At 12:54 p.m., CNA #1 was observed to leave Resident #11 at the table with Resident #11's representative. At 12:57 p.m., CNA #1 offered for Resident #11 and Resident #11's representative to leave the dining hall to have a visit instead of eating which was accepted by the resident representative. At 12:58 p.m., Resident #11 was assisted out of the dining hall by CNA #1. Resident #11 was observed to eat less than 25% of the lunch meal and less than 25% of his beverage. -The facility served Resident #11's lunch meal was delivered more than one hour after he was assisted to the dining hall. -The facility did not provide extra time for Resident #11 to eat the lunch meal as identified in his nutritional plan of care (see documentation and interviews below) -The facility failed to offer a food alternative when Resident #11 was observed to eat less than 25% of the lunch meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Resident representative interview Resident #11's representative was interviewed on 11/6/24 at 1:05 p.m. Resident #11's representative said Resident #11 had been actively declining while receiving hospice services recently. Resident #11's representative said there was a meeting today to discuss whether or not interventions should be changed further to reflect where Resident #11 was in his end of life care journey. Resident #11's representative said Resident #11 should be offered food alternatives if he ate very little at the meal. Resident #11's representative said Resident #11 required extra time to eat and drink because his intake pace had slowed in recent months. Resident #11's representative said Resident #11 should not have to wait more than an hour to receive his food after he was assisted to the dining hall. Resident #11's representative said he did not know how long Resident #11 had been eating in the dining room for lunch on 11/6/24 when he was offered to have a visit with Resident #11 instead of continuing to provide Resident #11 with meal service assistance. Resident #11's representative said the family did not provide assistance at meals. D. Record review The nutrition care plan, initiated on 2/9/23 and revised 10/28/24, revealed Resident #11 had the potential for unintentional weight loss and was initiated on hospice care. The interventions included providing assistance at meals as needed and as the resident allows, allowing ample time to consume food and fluids, monitoring the resident's intake, positioning the resident upright at meals as close to 90 degrees as possible while maintaining resident comfort and not to feed the resident if he appeared lethargic. A review of Resident #11's EMR revealed the following physician's orders: -Sit upright to eat and 30 minutes after, try to complete oral care after each meal, use a swab with mouthwash to clear residue on teeth, cheeks and tongue, ordered on 5/25/23. -Slow feeding, nectar thickened fluids. If the resident coughs hard or chokes during feeding, stop feeding for adequate time for the resident to recover, resume feeding and if coughs hard or chokes a second time stop feeding for that meal, ordered on 8/3/24. The Quick training documentation, dated 8/12/24, was provided by the director of nursing (DON) on 11/7/24 at 3:41 p.m. It documented that 12 bedside nursing staff members were educated Be sure to allow [Resident #11] to rest if he starts to cough. Then attempt to assist after adequate resting. If coughing continues, stop assisting with meal and notify the nurse. The 10/7/24 dietary data collection documented Resident #11 was normally eating 25-50% of all meals. The dietary data collection documented that Resident #11 had experienced weight loss in the last six months because of his declining condition. The dietary data collection documented that this was expected weight loss because Resident #11 was receiving hospice care services. The dietary data collection documented that Resident #11 required total assistance with meals. The dietary data collection documented that Resident #11 was accepting thickened liquids. -However, Resident #11 was not observed to receive consistent meal assistance on 11/4/24 and 11/6/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospice visit note, dated 10/9/24, documented that Resident #11 required assistance with all ADL's. The hospice visit note documented Resident #11 required assistance with all meals including meal preparation, meals being fed to Resident #11, and that Resident #11 coughed with food and fluids. The hospice note documented Resident #11 had difficulty swallowing. The hospice visit note documented that Resident #11 was unable to communicate his needs. III. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), Alzheimer's disease, and severe dementia without behavioral disturbance. The 10/7/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. The assessment documented Resident #18 required substantial or maximum assistance with eating and oral hygiene, and was dependent on nursing staff for all other cares and activities of daily living (ADL). The assessment documented Resident #18 continuously presented with inattention and disorganized thinking. The assessment documented Resident #18 had no rejections of care. B. Observations During a continuous observation in the dining room on on 11/4/24, beginning at 11:27 a.m. and ending at 12:42 p.m., Resident #18 was eating vegetable lasagna from a regular plate. Resident #18 ate less than 25% of this lunch meal. -Resident #18 was not offered a lipped plate as identified in his nutritional plan of care (see record review below). -Resident #18 was not offered an alternative food option after consuming less than 25% of the meal. C. Record Review The nutrition care plan, initiated on 2/9/23 and revised on 10/28/24, revealed Resident #18 had the potential for unintentional weight loss because of his COPD diagnosis, history of weight loss, diagnosis of essential tremors affecting intake and general decline. The care plan documented his goal was to slow and minimize weight decline. The interventions included providing a lipped plate, handled cups, and may use weighted utensils if requested, encouraging the resident to sit in the dining room for meals, having food available when the resident was hungry, offering the resident assistance at meals as needed, providing a lidded cup for soups and milkshakes due to tremors, allow ample time to consume food and fluids, and to monitor the resident's intake. The 10/7/24 dietary data collection documented Resident #18 normally ate 50-75% of all meals. The dietary data collection documented Resident #18 required adaptive equipment to eat including a lipped plate and a cup with both a lid and handles. Resident #18's weight decline was expected and was related to an overall decline in Resident #18's condition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, Resident #18 did not receive a lipped plate during meal observations on 11/4/24. On the Spot Training documentation was received from the nursing home administrator (NHA) on 11/7/24 at 3:26 p.m. (during the survey) The training documented While assisting residents with meals once we start we should not be getting up and down. Our focus should be focusing on maximum nutrition. If the resident is refusing to eat, offer a different option. If the resident is eating less than 50% of their meal, offer another option. III. Staff interviews CNA #1 was interviewed on 11/6/24 at 1:21 p.m. CNA #1 said if a resident ate less than 25% of their meal, an alternative meal option should be offered and the nurse should be notified. CNA #1 said that when staff members assist residents with eating one on one they should stay with the resident for the duration of the meal unless there is an emergency. CNA #1 said that residents should always receive the adaptive equipment needed to safely eat. -However, CNA #1 was observed to leave Resident #11 to assist other residents in the dining hall on 11/4/24 and 11/6/24 dining observations. The registered dietitian (RD) was interviewed on 11/6/24 at 1:41 p.m. The RD said that Resident #11 and Resident #18 required end of life care services. The RD said that residents requiring extra time to eat their meal should be given what time they need to eat what they want to eat. The RD said offering food to Resident #11 for less than 30 minutes was not appropriate because Resident #11 needed more time to eat. The RD said it was inappropriate for residents to be served their meal more than one hour after they are assisted to the dining hall. The RD said that if a resident eats less than 25% of their meal, a meal alternative should be offered. The RD said nursing staff should follow identified interventions in the nutritional plan of care. The RD said it was expected for Resident #11 and Resident #18 to have weight loss because they are both receiving end of life care services. CNA #3 was interviewed on 11/6/24 at 4:22 p.m. CNA #3 said residents should always be provided with the appropriate adaptive equipment. CNA #3 said that residents should be offered a meal alternative if they eat less than 25% of their meal. CNA #3 said CNA's at the facility try to stay with a resident, but that did not always happen. Registered nurse (RN) #1 was interviewed on 11/7/24 at 10:24 a.m. RN #1 said that if a resident ate less than 25% of a meal, then an alternative meal option should be offered. RN #1 said that it was important to make sure residents have the appropriate adaptive equipment so they have the ability to eat independently. The director of nursing (DON) was interviewed on 11/7/24 at 3:42 p.m. The DON said Resident #11 and Resident #18 required end of life care services and weight loss was expected in both residents. The DON said she did not know why Resident #11's meal service was significantly delayed at lunch on 11/6/24. The DON said she expected staff members to stay with residents requiring meal assistance throughout the meal unless an emergency occurred. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said facility staff should not be leaving residents alone without assistance during the meal service. The DON said that Resident #11 should have been offered fluids more frequently on lunch meal services that took place on 11/4/24 and 11/6/24. The DON said that residents should always be offered a meal alternative if they eat less than 25% of their meal. The DON said residents should be offered adaptive equipment identified in the nutritional plan of care. The DON said that if a resident required extra time to eat their meal then staff should offer assistance as long as the resident needs. The DON said that Resident #11 did not receive extra time to eat his meal on lunch observations that took place on 11/4/24 and 11/6/24. The DON said she was not aware Resident #18 did not receive a lipped plate for the vegetable lasagna served for lunch on 11/4/24.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40467

Based on observations, record review and interviews, the facility failed to ensure one (#10) of two residents reviewed for pressure injuries out of 20 sample residents received care and services necessary to prevent the development of pressure injuries.

Specifically, the facility failed to ensure staff consistently followed the care planned wound prevention interventions for Resident #10, who had a facility-acquired pressure ulcer.

Findings include:

I. Professional reference

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://www.internationalguideline.com/guideline on 10/8/24,

Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with non blanchable 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 individual with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk).

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. The 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/Stage3 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 ulcer can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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) on 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

The Prevention and Treatment of Pressure Ulcers/Pressure Injuries policy, dated 11/22/22, was provided by the director of nursing (DON) on 11/7/24 at 5:49 p.m. It read in pertinent part, It is the policy of the facility to properly identify and assess residents whose clinical conditions increase the risk of impaired skin integrity, and pressure room, preventive measures and to provide appropriate treatment modalities for wounds according to professional standards of care.

III. Resident #10

A. Resident status

Resident #10, age greater than age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included chronic systolic (congestive) heart failure, atherotherosclerolic heart disease of the native coronary artery without angina pectoris (hardening of the arteries from plaque build impacting blood flow), type two diabetes mellitus without complications, weakness, and audio and visual hallucinations.

The 8/9/24 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. Resident #10 exhibited inattention or disoriented thinking.

According to the MDS assessment, the resident was at risk for developing pressure ulcers and received hospice care.

B. Resident interview

Resident #10 was interviewed on 11/5/24 at 4:18 p.m. Resident #10 was not able to say if he had wounds on his feet or if he was comfortable with his heel protective boots and heel offloading device in place. The resident said he was not in pain.

C. Observations

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Horizons Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11411 Highway 65 Eckert, CO 81418	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 11:58 p.m. Resident #10 was sleeping in his bed. His heel offloading device was sitting on the floor next to the wall, between his bed and his closet. Resident #10 did not have a heel offloading device under his legs to offload the pressure on his heels. At 3:34 p.m. Resident #10 was sleeping in his bed. His heel offloading device remained off the bed and in the same location. The heel offloading device was not in place to offload the pressure on the resident's heels as he laid in bed. On 11/5/24 at 12:58 p.m. wound care for Resident #10 was provided by licensed practical nurse (LPN) #2, registered nurse (RN) # and the DON. After completing the wound care, the DON placed a bolster wedge upright between the resident's footboard and Resident #10's heel protective boots. There was no visible space between the wedge and the Podus boot. The bottom of the resident's heel protective boots were slightly compressed against the surface of the bolster wedge, which did not allow the resident's heels to be appropriately offloaded. At 4:10 p.m. Resident #10 was sitting in the lobby in a wheelchair. The resident was wearing slippers on his feet. The foot pedals of his wheelchair were folded up against each side of the wheelchair and not in use. Resident #10 requested the activity assistant (AA) take him to the living room to watch television as he waited for dinner. The AA proceeded to assist Resident #10 in his wheelchair down the hall towards the living room. Resident #10's slippered feet skimmed the surface of the floor as he was pushed in his wheelchair. -The AA did not unfold the resident's wheelchair foot pedals and place his feet on the foot pedals before he was transported down the hall. On 11/6/24 at 4:10 p.m. Resident #10 was awake in bed. He did not have his heel protective boots on his feet. The heel offloading device device was not in place and his heels were not offloaded off of the bed. The bolster wedge was at the head of the resident's bed. On 11/7/24 at 9:27 a.m. Resident #10 was assisted to bed by certified nurse aide (CNA) #4 and another staff member. At 9:35 a.m. Resident #10 was in bed after CNA #4 and the other staff member assisted him to bed. The resident's heel offloading device was up against the wall and not placed under the resident's legs to float his heels and offload the pressure from his heels. At 9:57 a.m. Resident #10 was sleeping in bed. His heel offloading device remained up against the wall on the floor. D. Record review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The skin care plan, revised 11/4/24, documented Resident #10 was at risk for skin breakdown on his heels from poor nutrition, impaired mobility and his preference to stay in bed. According to the care plan, heel protectors were in use. According to the care plan, the resident occasionally declined to float his heels. Interventions included offering the resident repositioning assistance if needed when he laid bed (initiated 2/15/24), providing heel protective boots to the resident while he was in bed to prevent skin breakdown to his heels and ankles related to his preference to frequently stay in bed (revised 10/22/24), providing verbal cues to the resident during transfers to assure safety and decrease risk of injury (initiated 10/21/24) and providing the resident a heel offloading device, if the resident allowed, to reduce pressure to his heels. The resident was re-educated on the need to use the heel protective boots and the heel offloading device (revised 9/25/24). The 8/6/24 Braden Scale for Predicting Pressure Sore Risk assessment documented Resident #10 was at moderate risk for developing a pressure sore. According to the assessment, the resident had very limited sensory perception, had very limited mobility, requiring moderate to maximum assistance in moving and had the potential for inadequate nutrition. The 10/22/24 Braden Scale assessment for Resident #10 documented he remained at a moderate risk for pressure injury. Review of the November 2024 CPO revealed the following physician's orders: Resident #10 was admitted to hospice related to congestive heart failure, ordered 8/12/24. Offload heels at all times, especially his left heel, twice a day for his wound, ordered 9/25/24. Wound care left heel: Cleanse with a wound cleanser, apply Santyl (wound treatment used to remove damaged tissue from wounds) to the slough (yellow/white dead tissue) in wound bed, apply Calcium Alginate (wound treatment) to wound bed and cover the wound with a foam dressing that extends out from the wound. Changed every five days and PRN (as needed), ordered 10/29/24. The 9/25/24 eInteract situation background assessment recommendation (SBAR) post incident review documented Resident #10 had a stage two pressure wound to his left heel. The 9/29/24 IDT post incident note documented Resident #10 raised the head of his bed independently and lowered his feet independently, which removed the heel offloading device, pushed his feet against the footboard and frequently slid down in bed. The resident's legs would extend over the footboard. The resident had potential risk of injury to his feet and toes related to self propelling his wheelchair or kicking his legs over the side of the bed. According to the IDT note, Resident #10 was provided a heel offloading device, heel protective boots and wound care as ordered by the physician. The 10/30/24 IDT review note documented Resident #10 received continued education for floating his heels and using heel offloading devices for his bilateral lower extremities. According to the note, Resident #10 verbalized and demonstrated positive results for reinforcement of the education. The 11/3/24 skin/wound evaluation indicated Resident #10 was educated to keep his heels floated. According to the care plan, the resident would kick the heel protectors off the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's progress noted between September 2024 and November 2024 did not identify the resident refused heel offloading interventions (see interviews below). A 11/7/24 On the Spot staff training with the AA was provided by the corporate consultant (CC) on 11/7/24 at 2:53 p.m. The training documented the AA was provided training (during the survey) not to push residents in their wheelchairs without their feet on the foot pedals to prevent friction on the residents' feet. A 11/7/24 On the Spot staff training for foot pedals was provided by the CC on 11/7/24 at 2:53 p.m. Eight staff members received the training on 11/7/24 (during the survey). The training informed staff to make sure a resident's feet were not dragging when a resident was transported with a wheelchair. According to the training, staff should use foot pedals to ensure the resident's feet did not touch the floor because it increased the risk for skin breakdown. A 11/7/24 On the Spot staff training was provided by the CC on 11/7/24 at 2:53 p.m. The training documented twelve staff members received training on 11/7/24 (during the survey) regarding bolster wedges. According to the training, bolsters should be placed at the top of the bed to prevent added pressure to the foot of the bed. IV. Staff interviews LPN #2 was interviewed on 11/6/24 at 4:41 p.m. LPN #2 said Resident #10 had a pressure wound on his foot. She said hospice had determined it to be unavoidable as of the morning of 11/6/24 but she had not added the order to his electronic medical record (EMR) yet. LPN #2 said she believed the pressure ulcer on his foot was from his footboard on his bed. She said Resident #10 would use his bed controller to raise the head of his bed up and then he would slide to the foot of his bed. She said he would prop up his feet on his footboard. She said protective interventions had been put in place to reduce the pressure of his heels and decrease the risk of his pressure reducing mattress moving and sliding down, touching the foot board with heels. LPN #2 said Resident #10 had soft heel protective boots, a heel offloading device under his lower legs as he laid in bed and a bolster wedge to help keep the mattress in place so it would not slide down when he lifted the head of the bed and to reduce the risk for pressure to the resident's feet. LPN #2 said the bolster wedge should be positioned at the head of the bed and not the foot of the bed to keep the mattress in place. LPN #2 said Resident #10 should wear his heel protective boots when he was in bed to offload his heels and reduce pressure. LPN #2 said Resident #10 was at risk for pressure ulcers because he had poor circulation, refused nutritional interventions and self propelled his wheelchair. She said staff needed to ensure interventions were in place to help decrease Resident #10's pressure ulcers from worsening and help prevent new pressure ulcers from developing. LPN #2 said staff needed to help reposition him every two hours during the day and every four hours at night, put on his heel protective boots and place his heel offloading device under his lower legs so his heels could float. She said he should have his heel offloading device in place every time he was in bed. LPN #2 said the CNAs and the nurses should do visual checks on the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 said the foot pedals on Resident #10's wheelchair should be used when staff propelled his wheelchair to prevent injury and reduce friction between his feet and the floor. She said Resident #10 could only hold his feet up for short distances. LPN #2 said staff should reapproach and encourage the use of his pressure reducing and prevention interventions and document the resident's refusals to offload his heels. CNA #4 was interviewed on 11/7/24 at 10:07 a.m. CNA #4 said Resident #10 should be repositioned every two hours, his heel protective boots should be on and his heel offloading device should be in place when he was in bed CNA #4 said the resident would take his heel protective boots off when he wanted to get up and out of bed but she said otherwise, Resident #10 was compliant with wearing the heel protective boots if he was given a reminder on why he needed to wear them. The DON and the CC were interviewed on 11/7/24 at 12:10 p.m. The DON said Resident #10 had been on hospice services since 8/6/24 but because of his declining circulation, the physician determined the development of pressure ulcers were unavoidable. She said the 11/6/24 order had not yet been uploaded to his EMR. The CC said failure to follow wound interventions could increase the risk for worsening of the pressure ulcer and would be considered an avoidable development. She said all wound prevention interventions should be consistently followed. The CC and the DON said the heel offloading device should be in place when Resident #10 was in bed. The DON said staff should not push his wheelchair when his feet were not on his foot pedals due to the risk of injury. The DON said there was some confusion on where the bolster wedge should be placed on Resident #10's bed. She said the staff was placing the wedge at the foot of the bed as a buffer between his feet and the footboard. She said it was determined the wedge should be at the head of the bed to help reduce the risk of the air mattress sliding down and decreasing the risk of his feet touching surfaces that could contribute to pressure. The DON said she would be providing staff education related to the placement of the bolster wedge.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40467

Based on observations, record review and interviews, the facility failed to provide respiratory care services for one (#8) of two residents reviewed for respiratory care services out of 20 sample residents.

Specifically, the facility failed to ensure oxygen was administered as ordered by the physician for Resident #33.

Findings include:

I. Facility policy and procedure

The Oxygen Administration, Long Term Care, [NAME] policy and procedures, revised 12/11/23, was provided by the director of nursing (DON). According to the procedures, oxygen administration supplies the body with enough oxygen to meet its cellular needs. The implementation of oxygen administration required verifying the practitioner's (physician) orders, assisting in the placement of the prescribed oxygen delivery device on the resident, making sure that the oxygen device fit properly and adjusting the oxygen flow rate as ordered. Staff should not administer oxygen nasal cannula at more than 2 (two) liters per minute (lpm) to a resident with chronic lung disease, unless there was a specific order to do so.

The Lippincott procedures for oxygen identified a nasal cannula as an oxygen administration system. The plastic cannula (tubing) delivered oxygen into the resident's nostrils. According to the procedures, the cannula could become easily dislodged.

II. Resident #8

A. Resident status

Resident #8, age greater than age 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included chronic respiratory failure with hypoxia (lungs unable to adequately exchange oxygen, leading to low oxygen levels), dependence on supplemental oxygen, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, hallucinations and reduced mobility.

The 8/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She did not exhibit inattention or disoriented thinking. She was dependent on staff for most of her activities of daily living (ADLs). According to the MDS assessment, the resident had shortness of breath or trouble breathing with exertion and when laying flat. The assessment identified the resident required continuous oxygen therapy. The resident did not have behaviors or rejections of care.

B. Observations and resident interview

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 1:20 p.m. Resident #8 was lying in bed. Resident #8's eyes were closed and her mouth was open as she took shallow breaths. Her oxygen concentrator was turned on and set at 3 liters per minute of oxygen (LPM). Her nasal cannula, attached to the oxygen concentrator, was not in her nostrils and was laying on her chest. Resident #8 kept her eyes closed as she lifted up the nasal cannula, brought it up near her and then placed it back down on her chest. The resident roused when her name was called. The resident said she was not feeling well and had some shortness of breath (SOB). Resident #8 placed her nasal cannula in her nostrils and turned on her call light. The nurse entered the room. Resident #8 was interviewed on 11/5/24 at 10:50 a.m. Her oxygen concentrator was set at 2 LPM. She said her nasal cannula would often come off when she was sleeping. She said she would place it back in her nostrils when she woke up. Resident #8 said she would become short of breath when she was not not wearing her nasal cannula. She said she also had difficulty breathing if the water container attached to the oxygen contractor was low. She said the water container would sometimes run out of water or the water level would run low which made it harder for her to breathe. She said she tried to watch the water level from her bed and make sure there was enough water in the container. Resident #8 said she had to remind the staff to fill the water container. On 11/6/24 at 1:32 p.m. Resident #8 was in her room. Her oxygen concentrator was set at 3 LPM and the water container was less than half full. The resident said the oxygen should be set at 2 LPM and she did not know why it was set at 3 LPM. The resident said the water in her oxygen concentrator was less than half full and said she wanted it filled because she was nervous it might run out of water. Resident #8 requested for a nurse to look at her oxygen LPM setting and the water level in the water container. At 1:40 p.m. registered nurse (RN) #2 entered Resident #8's room and observed the resident's oxygen concentrator set at 3 LPM. RN #2 told the resident her oxygen was set too high and turned it down to 2 LPM. RN #2 checked Resident #8's oxygen saturation levels. RN #2 asked the resident to take in some deep breaths. The resident, confused by the directions, held her breath. RN #2 reminded Resident #8 to breathe normally and her saturation levels rose to 92%. RN #2 observed the water level in the container attached to the resident's oxygen concentrator. RN #2 told the resident the water level was less than half full and it should be over half full. RN #2 filled the water container. C. Record review A 6/6/24 nursing agenda was provided by the DON on 11/7/24 at 4:57 p.m The agenda identified oxygen was reviewed with the nurses. -The agenda did not identify what was reviewed with the nurses regarding oxygen. Review of Resident #8's November 2024 CPO revealed the following physician's orders: Continuous oxygen set at 2 LPM via nasal cannula every shift for cough, congestion related to chronic respiratory failure with hypoxia and heart failure, ordered 8/13/24. Document if the resident had shortness of breath every shift related to heart failure with the following codes: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-(1) no SOB; -(2) SOB at rest; -(3) SOB with exertion; and, -(4) SOB while lying flat, ordered 8/13/24. Interview resident, family members, and/or staff for any noted shortness of breath when the resident attempts to lie flat, or avoids lying flat because of shortness of breath. Observe the resident during various activities, sitting at rest, and when in bed and document in progress notes, ordered 8/13/24. Check and clean or change oxygen supplies every Saturday during the night shift, ordered 8/13/24. The oxygen care plan, revised 10/21/24, documented Resident #8 required oxygen at 2 LPM via nasal cannula related to a diagnosis of heart failure. The care plan directed staff to change her oxygen tubing weekly and PRN (as needed), monitor and document level of consciousness, mental status, and lethargy PRN and notify the nurse if oxygen saturation levels dropped under 90% (percent). A 10/21/24 oxygen audit was provided by the DON at 4:35 p.m. The audit documented 12 residents with supplemental oxygen who were reviewed for oxygen care plans and physician orders in place. According to the audit, Resident #8 had physician orders for oxygen at 2 LPM and her care plan was in place. The November 2024 oxygen saturation log, between 11/2/24 and 11/5/24, documented the resident's oxygen saturation levels were checked two to three times a day and ranged between 91% and 96%. The November 2024 medication administration and treatment record (MAR/TAR), reviewed from 11/1/24 through 11/5/24, documented Resident #8 had experienced SOB daily with exertion and when laying flat. The oxygen care plan, revised 11/7/24 (during the survey), revealed Resident #8 expressed concerns over the concentrator water level being below the minimum fill line. The resident felt she was able to breathe better with the water at a higher level. The care plan directed staff to check the resident's water bottle on the concentrator to ensure that it was filled at the maximum water level and ensure the resident had her oxygen tubing placed on her face. An On The Spot training sheet was provided by the corporate consultant (CC) on 11/7/24 at 3:37 p.m. The training was conducted on 11/7/24 (during the survey). The training sheet identified that 13 staff members were told the nurses were the only ones that could touch residents' oxygen settings. According to the training, if a resident was requesting more oxygen, staff should notify their nurse so that the correct procedures could be followed with obtaining a physician's order. Staff should ensure the oxygen tubing was in the nasal canal and not laying on the resident's face. Staff were also reminded to make sure the water was filled to the proper level on the oxygen concentrator D. Staff interviews (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 11/6/24 at 1:36 p.m. RN #2 said she thought Resident #8's oxygen setting should be 3 LPM but would need to confirm it. RN #2 reviewed Resident #8's oxygen order and said the resident's oxygen concentrator should be set at 2 LPM per the physician's order. She said only nurses were allowed to adjust the oxygen settings on the concentrator. She said she had been Resident #8's nurse all day and she had not adjusted the resident's oxygen setting. RN #2 said the only reason for the increase in LPM would be if the resident was desaturating, but she said the last documented oxygen saturation level (amount of oxygen in the blood) was 98% on 11/5/24. She said a certified nurse aide (CNA) should not adjust the oxygen setting and the resident was not physically able to adjust the oxygen setting herself. RN #2 was interviewed a second time on 11/6/24 at 1:49 p.m. RN #2 said she would fax the physician and ask if there should be any changes to her oxygen orders and confirm what LPM her oxygen concentrator should be set at. CNA #1 was interviewed on 11/6/24 at 1:51 p.m. CNA #1 said the water level in the water container on the oxygen concentrator should be maintained above the minimal line. She said the oxygen concentrator should be set according to the nurse's directive. She said CNAs were never allowed to adjust the oxygen settings on residents' oxygen concentrators. CNA #3 was interviewed on 11/7/24 at 9:30 a.m. CNA #3 said Resident #8's nasal cannula frequently fell off her face at night and sometimes during the day when the resident slept. She said the resident did not take it off on purpose and it was very important to Resident #8 that she had it in her nose. CNA #3 said the resident was receptive to having staff assist her with wearing her nasal cannula and would not resist or decline the oxygen use. CNA #3 said Resident #8 would get short of breath if she was not wearing her nasal cannula, if the tubing had a kink in it which would limit the oxygen flow and if the water level in the water container on the oxygen concentrator was low. She said she tried to keep the water level in the container more than half full. She said Resident #8 told her that the water levels impacted her breathing and she would watch the water level. CNA #3 said Resident #8's oxygen concentrator was usually set between 2 LPM and 3 LPM. She said she could adjust the oxygen setting if she confirmed the setting with the nurse. RN #2 was interviewed a third time on 11/7/24 at 9:16 a.m. RN #2 said there was not a change in Resident #8's oxygen flow rate since the 11/6/24 observation. She said the resident's oxygen order remained at 2 LPM and she did not have a physician's order to titrate (adjust oxygen flow rate) the resident's oxygen to a different flow rate. RN #2 said she had spoken to the night shift nurse who said the resident would sometimes insist on having her oxygen setting increased. RN #2 said the physician's orders should be followed. She said an oxygen saturation level of 98% was pretty high for the resident. She said the resident's usual oxygen saturation levels were around 95% and did not usually drop under 90%. The DON was interviewed on 11/7/24 at 11:53 a.m. The DON said it was not appropriate for physician's orders not to be followed. She said only nurses were allowed to set the LPM on the residents' oxygen concentrators. She said the nurse should only adjust the setting based on the physician's order for oxygen. The DON said if Resident #8's oxygen setting was increased then there should have been a documented rationale and the physician should have been contacted. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the water level in the water container on the oxygen concentrator should be monitored every shift and be between the minimum and the maximum level lines. She said Resident #8 worried about the water level and had a fear of running low on the water level. The DON said the resident wanted the water level to be maintained at the maximum water line to ease her worry. She said the resident's preference on the water container level on the oxygen concentrator was not care planned but it should have been. She said staff should check her water levels each time they went into her room. The DON said Resident #8 did not take off her own nasal cannula. She said staff checked on Resident #8 every two hours during rounds. The DON said she would update the CNA task sheet and the resident's MAR to include more frequent observations with Resident #8 because the nasal cannula would fall off when the resident was sleeping. The quality assurance and improvement coordinator (QAIC) was interviewed on 11/7/24 at 5:18 p.m. The QAIC said oxygen was reviewed in the facility's quality assurance and improvement committee but oxygen had not been identified as a recent concern. She said audits were conducted and there were no concerns found. She said the staff were doing what they were supposed to be doing. She said it had been a while since staff had received education related to oxygen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40467 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure hand hygiene was conducted appropriately; and, -Santitize potentially contaminated surfaces of a food preparation counter. Findings include: I. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 10/22/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The Center for Disease Control and Prevention (CDC) About Hand Hygiene For Patients in Healthcare Settings (2/27/24), retrieved on 10/22/24 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html, read in pertinent part, Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. According to the CDC, hand washing should occur before preparing or eating food, before touching the eyes, nose or mouth, and after touching potential contaminated surfaces. II. Facility policy and procedure The Hand Hygiene policy, dated 8/19/24, was provided on 11/7/24 by the facility. The policy read in pertinent part, The hands are the conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to a patient, and from a staff member to a patient. Because of this, hand hygiene is a single most important procedure to prevent infection to protect patients from Healthcare Associated infection, hand hygiene must be performed routinely and thoroughly. B. Observations (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 of the lunch meal service in the main kitchen and dining room on 11/6/24, beginning at 11:10 a.m and ending at p.m., the following was observed: At 11:27 a.m. cook (CK) #1 proceeded to take the temperature of the lunch meal items with a food thermometer and then placed them in the steam table for service. At 11:33 a.m. CK #1 dropped the thermometer onto the kitchen floor, the casing around the indicator head loosened from the drop. She quickly picked up the thermometer, snapped the loosened parts back together and placed the thermometer on the food preparation counter. CK #1 picked up the thermometer and wiped it down with an alcohol wipe and placed it back down on the food prep counter. CK #1 did not perform hand hygiene after she picked up the thermometer off of the floor. CK #1 did not sanitize the food preparation counter after setting the contaminated thermometer on it. -CK #1 continued to prepare for the upcoming meal service without ensuring her hands were clean after the contact with an item that fell on the floor between 11:35 a.m. and 11:45 a.m. At 11:35 a.m. CK #1 retrieved a pan from the pan rack. She left the main kitchen and filled the pan with ice at the drink station behind the service line window. She returned to the kitchen and placed the thermometer probe into the ice. CK #1 did not perform hand hygiene after she returned to the kitchen and after she touched high touch surfaces such as the ice scoop and the lid of the ice machine. She retrieved a large serving spoon and placed it on the unsanitized food prep counter. At 11:39 a.m. CK #1 left the kitchen and retrieved hot water from the drink station, touching high touch surfaces such as the handle of the hot water container. She returned to the kitchen and proceeded to puree Italian crusted fish. She placed the puree fish on the steam table. At 11:45 a.m. CK #1 washed her hands. This was the first time CK #1 washed her hands, after she picked up the food thermometer off the floor. At 11:50 a.m. certified nurse aide (CNA) #1 waited at the backside of the meal service window in the drink station area for the meal service to begin. CNA #1 touched her face under her eye and the side of her nose. She did not perform hand hygiene after touching her face. At 11:53 a.m. without performing hand hygiene after touching her face, CNA #1 filled a resident's drink container with milk and gave it to the resident. She removed the paper for a straw and placed it in the beverage. She returned to the drink station and performed hand hygiene. At 11:57 a.m. CNA #1 she touched both sides of her face as she waited for the meal service to begin. She did not perform hand hygiene after touching her face. At 11:59 p.m. meal service began. Without performing hand hygiene after touching her face, CNA #1 retrieved a plate from the service window, served a resident in the dining room and used the resident's utensils to help cut up the resident's food. CNA #1 returned to the drink station and performed hand hygiene. At 12:10 p.m. CNA #1 touched both sides of nose and placed her hands in her pockets as she waited to serve the next resident. She did not perform hand hygiene after touching her face. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:53 p.m. without performing hand hygiene after touching her face, CNA #1 sat between two residents who needed meal assistance. CNA #1 provided a bite size piece of food to a resident to her right using her right hand to pick up the utensil. The resident cleared his throat after swallowing the food. CNA #1 did not use hand hygiene after assisting the resident. At 12:54 CNA #1 provided a bite size piece of food to the resident to her left, using her right hand. CNA #1 did not perform hand hygiene before assisting the resident. CNA #1 did not use hand hygiene after assisting the resident. C. Record review A September 2024 All Staff Agenda was provided by the nursing home administrator (NHA) on 11/7/24 at 3:26 p.m. The agenda indicated staff were reminded to use hand hygiene during meals with residents. Employee sanitation practice training was provided by the NHA on 11/7/24 at 3:26 p.m. The training was conducted on 11/7/24 (during the survey). According to the training employees should wash their hands just before they start to work in the kitchen after smoking, sneezing, using the restroom, handling poisonous compounds, dirty dishes, touching of the face, hair, other people /or surfaces or items with potential for contamination. D. Staff interviews CNA #1 was interviewed on 11/06/24 at 1:51 p.m. CNA #1 said hand hygiene should have been conducted before serving residents their meals, when assisting a resident to eat, after touching body or clothes surfaces or any time the staff touch a potentially contaminated surface. The dietary manager (DM) was interviewed on 11/6/24 at 1:59 p.m. The DM said staff should perform hand hygiene anytime the hands were soiled, entered the kitchen, when changing gloves, and/or touch potentially contamination surfaces to prevent cross contamination of the food or food surfaces. The DM said hand washing should have been conducted if a staff member picked up an item from the floor. She said the staff serving the meals should perform hand hygiene throughout the meal service and after touching a potentially contaminated surface. The DM said body parts, hair nets and clothing were considered a potentially contaminated surface and staff should perform hand hygiene if they touch potentially contaminated surfaces when serving food and/or food related items. She said all food related surfaces should be kept clean. The DM said staff received routine hand hygiene training through the facility's online training program and as needed when corrections needed to be addressed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to ensure that the medical record was complete and accurate in keeping with accepted standards of practice for one (#9) of two residents reviewed for skin breakdown out of 20 sample residents. Specifically, the facility failed to conduct an accurate and thorough assessment of a resident's skin. Findings include: I. Resident #9 A. Resident status Resident #9, age greater than age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included gastroesophageal reflux disease with esophagitis without bleeding, acquired absence of other specified parts of digestive tract, personal history of transient ischemic attack (TIA), cerebral infarction with without residual deficits, Personal history of malignant neoplasm of other organs and systems, dysphagia, oropharyngeal phase, muscle weakness and reduced mobility. The 10/15/24 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 resident did not have limited range in motion with his upper or lower extremities. B. Resident observation and interview Resident #9 was interviewed on 11/4/24 at 2:19 p.m. Resident #9 had a large maroon colored bruise on his left forearm. The resident said bruises on his arms were common for him because he bumped into things. C. Record review The skin care plan, revised 9/4/24, identified Resident #9 had a high risk for skin breakdown due to having malnutrition and weakness. According to the care plan, the resident was able to reposition himself with the use of a positioning bar. The 10/30/24 nursing weekly skin check did not identify a bruise to the resident's arm. The 11/5/24 nursing weekly skin check did not identify a bruise to the resident's arm. The review of the October 2024 and the November 2024 progress notes did not identify a bruise on his arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, Resident #9 had a large bruise visible on his left forearm on 11/4/24 (see observation above). II. Staff interview The director of nursing (DON) was interviewed on 11/7/24 at 4:27 p.m. The DON said any bruises or breaks in residents' skin or changes in the color of the skin should be documented on a skin assessment. The DON said she observed Resident #9's left forearm bruise on 11/7/24 and the resident said he bumped it on the bedside table on 11/6/24. -However, Resident #9 had a large bruise visible on his left forearm on 11/4/24 (see observation above). The DON was informed the bruise was visible on 11/4/24. The DON said she would conduct an education with the nurses who worked with Resident #9 between 11/4/24 and 11/7/24. She said the nurses did not document they were aware of or assessed the bruise even though the bruise was in a visible location and should have been documented. She said Resident #9's skin was very fragile and the facility would look at padding his bedside table and positioning bar.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review, and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Implement an effective water management plan; -Appropriately discard Resident #8's medication that was dropped; and, -Provide proper infection control practices while maintaining an indwelling catheter. Findings include: I. Failure to have an effective water plan A. Professional reference According to Center for Disease Control (CDC), Legionella (Legionnaires Disease and Pontiac fever), last reviewed 3/25/21, was retrieved on 11/12/24 from https://www.cdc.gov/legionella/wmp/toolkit/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flegionella%2Fmaintenance%2Fwmp-toolkit.html and https://www.cdc.gov/legionella/wmp/overview.html. It read in pertinent part, Many buildings need a water management program to reduce the risk for Legionella growing and spreading within their water system and devices. Legionella bacteria are typically found naturally in [NAME] environments, but can become a health concern when they grow and spread in human-made water systems. Legionella can cause a serious type of pneumonia (lung infection) known as Legionnaires disease. Some water systems in buildings have a higher risk for Legionella growth and spread than others. Legionella water management programs are now an industry standard for many buildings in the United States. Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires disease. Legionella bacteria can also cause a less serious illness called Pontiac fever. The key to preventing Legionnaires disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key elements of a Legionella water management program are to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Establish a water management program team -Describe the building water systems using text and flow diagrams -Identify areas where Legionella could grow and spread -Decide where control measures should be applied and how to monitor them -Establish ways to intervene when control limits are not met -Make sure the program is running as designed (verification) and is effective (validation) -Document and communicate all the activities. Principles: In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for Legionella growth - Preventing water stagnation -Ensuring adequate disinfection -Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. A consultant with Legionella-specific environmental expertise may sometimes be helpful in implementing and operating water management programs. According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, reviewed 2/3/21, retrieved from on 4/1/24: Store hot water at temperatures above 140? and ensure hot water in circulation does not fall below 120?. Recirculate hot water continuously, if possible. Store and circulate cold water at temperatures below the favorable range for Legionella (77-113?); Legionella may grow at temperatures as low at 68?. B. Facility policy and procedure The Legionella Water Management Program policy was provided by the maintenance director (MTD) on 11/6/24 at 10:54 a.m. It documented in pertinent part, The purpose of the water management program is to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of legionnaire's disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Identify where potentially hazardous conditions could occur in the building water systems. Examples include areas where water temperature could promote Legionella growth or where water flow might be low. Establish control measures and limits for each hazardous condition. Control measures are actions taken in the building water systems to limit growth and spread of Legionella. They can include adding disinfectant, cleaning, and heating. C. Record review The facility's water management plan was provided from the MTD on 11/6/24 at 10:54 a.m. -The facility water management plan failed to document how resident rooms that were empty for seven contiguous days or more were safely protected from the potential growth of Legionella. The facility log, dated 11/6/24 at 2:11 p.m. (during the survey), documented the MTD had appropriately flushed all empty rooms in the facility to ensure Legionella had not grown in the facility. -However, the facility did not have documentation indicating empty rooms were appropriately were appropriately flushed to prevent potential Legionella bacteria growth prior to 11/6/24 (see interview below) The resident occupancy history data was provided by the nursing home administrator (NHA) on 11/6/24 at 2:43 p.m. It documented that in the last 60 days, the facility documented 12 rooms that were empty for seven contiguous days or more in resident care areas that were available for resident use. D. Staff interviews The MTD and the NHA were interviewed together on 11/6/24 at 1:31 p.m. The MTD said the facility used a system of hot water flushing and visual inspection of the water systems to ensure waterborne bacteria such as Legionella did not grow in the facility. The MTD said the facility's water systems had been upgraded many times over the years and he did not know where all the water pipes in the facility were. The MTD said it was possible there were old pipes with stagnant water in the facility that he did not know about. The MTD said that he flushed empty resident rooms on a rotating basis but did not document when he completed this task. The MTD said the normal process was to pick a few rooms on each hall each week and flush them appropriately. The MTD said he could not verify that all rooms that had been empty for seven contiguous days or more were appropriately flushed to prevent the potential growth of waterborne pathogens. The NHA said there was a potential risk of Legionella bacteria growth if water were to sit for seven contiguous days or longer. The MTD said he would immediately flush all empty rooms in the facility and change his documentation process starting on 11/6/24 to verify all empty rooms in the building had been flushed every week to prevent the potential growth of waterborne pathogens such as Legionella. II. Failure to administer medications appropriately (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Facility policy and procedure The General Dose Preparation and Medication Administration policy, dated 2021, was provided by the nursing home administrator (NHA) on 11/7/24 at 1:47 p.m. It documented in pertinent part: If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy. B. Observations and interviews On 11/6/24 at 8:50 a.m., medication administration was observed for Resident #8 with licensed practical nurse (LPN) #2. While removing the resident's Zyrtec (allergy medication) from the container, one Zyrtec pill fell on to the green top surface of the medication cart. LPN #2 then used two empty medication cups to pick up the medication without touching it and attempted to add the medication to the medication cup filled with clean medications already prepared for Resident #8. LPN #2 dropped the medication a second time on the green top surface of the medication cart. LPN #2 used the two spare medication cups again to scoop up the Zyrtec medication a second time and added it to the clean cup of prepared medications for Resident #8. LPN #2 then administered the entire cup of medications including the twice dropped Zyrtec to Resident #8. C. Staff interviews LPN #2 was interviewed on 11/6/24 at 9:09 a.m. LPN #2 said she did not sanitize or clean the green top of the medication cart before preparing medications for Resident #8. LPN #2 said if a medication was dropped on the floor it must be discarded, but if a medication was dropped onto the green medication cart top surface then it was acceptable to recover the medication and administer the medication to residents. Registered nurse (RN) #1 was interviewed on 11/7/24 at 10:24 a.m. RN #1 said if a nurse dropped a medication on the green top surface of the medication cart it must be discarded. RN #1 said it was important to ensure medications were not contaminated prior to administration. The director of nursing (DON) was interviewed on 11/7/24 at 3:42 p.m. The DON said medications that were dropped on the green top surface of the medication cart must be discarded. The DON said it was not appropriate for LPN #2 to attempt to recover the Zyrtec medication by using two empty medication cups in a scooping motion. The DON said LPN #2 should have discarded the dropped Zyrtec and obtained another clean Zyrtec from the medication bottle. 40467 III. Failure to provide proper infection control practices while maintaining an indwelling catheter A. Facility policy and procedure (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The Indwelling Urinary Catheter (Foley) care and Management policy, revised 12/11/24, was provided by the NHA on 11/8/24 at 3:04 p.m. The policy read in pertinent part,

Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI (catheter-associated urinary tract infection). However, do not place the drainage bag on the floor to reduce the risk of contamination and subsequent CAUTI.

B. Observations

Resident #10 was sleeping in his bed on 11/04/24 at 1:58 p.m. An indwelling catheter bag was attached to the side of his bed without a bag cover. The bottom of the resident's indwelling catheter bag touched the floor.

At 3:34 p.m. Resident #10 was still asleep in his bed and his catheter bag continued to touch the floor.

On 11/5/24 at 12:58 p.m. Resident #10's catheter bag was on the floor during the duration of a wound dressing change with LPN #2 and the DON. The catheter bag, without a cover, was under the bed and folded in half by the trash can in front of the bed.

At 1:33 p.m. LPN #2 picked the catheter bag off the floor and hung the bag off the side of the bed.

On 11/6/24 at 4:11 p.m. Resident #10's catheter bag was uncovered and was attached to the side of his bed. The bag hung approximately two to three inches above the floor. Certified nurse aide (CNA) #1 entered the room, stood up against his bed as spoke to Resident #10. CNA #1's shoes were observed directly under the catheter bag. The bottom of the bag touched the top of her shoes.

C. Record review

The 7/16/24 physician's order documented Resident #10 had a suprapubic catheter related to his diagnosis of a flaccid neuropathic bladder. According to the computerized physician's orders CPO, staff should check the catheter tubing every shift for proper positioning and catheter care.

The 2/15/24 catheter care plan read Resident #10 had a device that required continued monitoring and treatment. The care plan directed staff to monitor output every shift and provide adequate fluids to reduce infection potential. According to the care plan, the resident required assistance with care.

-The care plan did not direct staff to ensure the resident's catheter bag was covered, off the floor and away from surfaces that could potentially contaminate the bag.

D. Staff interview

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON was interviewed on 1/7/24 at 6:00 p.m. The DON said Resident #10's catheter bag should have been covered and off the floor to help ensure proper sanitation and keep germs and bacteria off the bag. She said contaminants could potentially get into the bag and use the tubing to travel up to the resident's bladder, causing an infection. She said the catheter bag on the floor was an infection control concern and she would re-educate the staff. She said the staff needed to be trained to keep his catheter bag covered and off the floor.