STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065274	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute	3185 W Arkansas Ave Denver, CO 80219

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 48114 Based on record review and interviews, the facility failed to ensure that personal funds accounts were managed adequately for four (#19, #22, #27 and #42) of 10 residents out of 31 sample residents. Specifically, the facility failed to have Resident #19, Resident #22, Resident #27 and Resident #42 sign a new resident fund management service (RFMS) authorization and agreement form to handle the residents' funds when the facility underwent a name change. Findings include: I. Facility policy and procedure The Management of Residents' Personal Funds policy, revised March 2021, was provided by the nursing home administrator (NHA) on 4/14/25 at 1:47 p.m. It read in pertinent part, The resident may have the facility hold, safeguard, and manage his or her personal funds. Should the resident elect to have the facility manage his or her personal funds, it is authorized in writing by the resident or the resident's representative, and a copy of such authorization is documented in the resident's medical record. II. Record review The Resident Fund Management Service Authorization and Agreement form was provided by the business office manager (BOM) on 4/10/25 at 10:50 a.m. -Review of the documentation revealed the facility's name was not accurate on the form for Resident #19, Resident #22, Resident #27 and Resident #42. III. Staff interviews The BOM was interviewed on 4/10/25 at 3:24 p.m. The BOM said she had only been working at the facility since November 2024. The BOM said the facility's name change happened in February 2023. The BOM said she was not working at the facility when the facility's name change occurred. She said the signature page for the residents to sign was printed off from the online RFMS program. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The BOM said she was not sure why Resident #19, Resident #22, Resident #27 and Resident #42 were not asked to sign a new RFMS authorization and agreement form when the facility changed its name. She said she thought the previous BOM had the residents sign a new form with the new facility name on it. She said she was unable to find a form with the facility's new name on the form for the four residents. She said if the residents had signed a new form, it would have been uploaded in the online RFMS system. She said Resident #19, Resident #22, Resident #27 and Resident #42 did not have a form with the facility's new name uploaded in the system. The BOM said she would have Resident #19, Resident #22, Resident #27 and Resident #42 sign a new RFMS authorization and agreement form and upload it to the RFMS system. The BOM said once she had the residents sign a new form, it would upload to the system right away. The NHA was interviewed on 4/10/25 at 3:40 p.m. The NHA said he was hired at the facility in January 2025 and was not at the facility when the name changed. The NHA said the facility's name change occurred in February 2023. The NHA said residents were informed about the name change. The NHA said senior management came to the facility and met with staff and residents to notify them of the name change. The NHA said the residents were asked to sign a new admission agreement but he was not sure if the residents were asked to sign a new RFMS. The NHA said the previous BOM would have context of what was said and done. The NHA said he could not answer as to why a new form was not signed by Resident #19, Resident #22, Resident #27 and Resident #42. The NHA said he attempted to contact the previous BOM to ask, but he said he was unsuccessful.

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 52094 Based on observations, record review and interview, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facilities most recent survey findings that included the survey results, certifications, complaint investigations and plans of correction in effect for the preceding three years. Specifically the facility failed to provide three years worth of survey and investigation findings in a prominent location for public viewing. Findings include: I. Resident group interview A group interview was conducted on 4/9/25 at 1:00 p.m. with six alert and oriented residents (#5, #35, #47, #48, #49 and #53), per the facility and assessments. The residents said they did not know where the binder containing the survey results was located. II. Observations On 4/10/25 at 10:59 a.m. the facility survey result binder was located behind the receptionist`s desk in the front lobby. The binder was not accessible and it had to be requested from the receptionist. The binder had a note that said to put out when the receptionist was at the desk, and to put in the cabinet when leaving for the day. The binder contained a survey from 3/7/24. -However the binder did not include the survey from 11/29/23, 9/28/23 and 5/1/24. III. Staff interviews The social service director (SSD) was interviewed on 4/10/25 at 10:45 a.m. The SSD said the survey results binder was not easily accessible to the residents and family members. She said the receptionist was not on site all day, so the survey binder was not available for residents or visitors around-the-clock. The nursing home administrator (NHA) was interviewed on 4/10/25 at 6:51 p.m. The NHA said he began working at the facility four months ago. He said that the binder should be easily accessible for the residents and families. He said it was his responsibility to ensure the book was up to date. He said had not identified the binder as an issue.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) Level II determination and evaluation from the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#40) of two residents reviewed for PASRR out of 31 sample residents. Specifically, the facility failed to arrange and incorporate recommendations from the PASRR Level II notice of determination (NOD) for Resident #40. Findings include: I. Resident #40 A. Resident status Resident #40, age 71, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia with mood disturbances, major depressive disorder, traumatic brain injury and schizophrenia. The 3/29/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. The assessment indicated the resident had no behaviors. The assessment revealed the resident had been identified as having a Level II PASRR. B. PASRR Level II Notice of Determination for MI (mental illness) evaluation Resident #40's PASRR Level II, provided to the facility on [DATE], included the evaluation which revealed the resident had been evaluated for MI due to a qualifying diagnosis of major depressive disorder. The resident was to receive a neurocognitive evaluation (an assessment to determine how different parts of the brain function to understand the impact of neurological conditions and brain injuries.) C. Record review Resident #40's mood and behavior care plan, revised 7/16/24, revealed the resident had a Level II PASRR due to a diagnosis of major depressive disorder and schizophrenia. Interventions, initiated dated 8/7/23, included to document all behaviors and provide medications as ordered. -The care plan failed to include the PASRR Level II recommendation for Resident #40 to have a neurocognitive evaluation (see PASRR Level II above). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The March 2025 CPO failed to reveal any orders for a neurocognitive evaluation since the resident's admission to the facility on [DATE]. -Progress notes were reviewed from 1/1/25 through 4/2/25 and no social services notes were found regarding PASRR or recommendations for Resident #40. There were no PASRR progress notes revealing communication with the State Mental Health Agency regarding a delay or inability to follow Resident #40's PASRR Level II recommendations. II. Staff interviews The social services director (SSD) was interviewed on 4/9/25 at 3:30 p.m. The SSD said the recommendations made by the State Mental Health Agency were included in the PASRR Level II and were the expectations of the state. The SSD said the facility had a provider that performed neurocognitive evaluations and she was aware of how to send a referral. She said during her quarterly and annual resident assessments, she reviewed if there were any changes in a resident's status that would require a review of the resident's PASRR. She said she did not know why a neurocognitive evaluation was never scheduled for Resident #40. III. Facility follow-up The SSD provided an update on Resident #40's PASRR recommendations on 4/10/25 at approximately 10:00 a.m. She said she had sent a referral for Resident #40 to receive a neurocognitive evaluation on 4/10/25 at 7:43 a.m.

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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** 46849 Based on observations, record review and interviews, the facility failed to ensure that services provided or arranged in accordance with the resident's plan of care were delivered by individuals who have the skills, experience and knowledge to do a particular task or activity for one (#20) of three residents out of 31 sample residents. Specifically, the facility failed to ensure Resident #20, who had a diagnosis of diabetes, had his fingernails cut by staff who were trained to perform the task. Findings include: I. Resident status Resident #20, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia, diabetes, quadriplegia, contractures of the left and right hands, diabetes and anoxic brain injury. The 3/19/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview of mental status (BIMS) score of six out of 15. The resident had impairments of both upper extremities and used a wheelchair to ambulate. The MDS assessment indicated the resident had a diagnosis of diabetes mellitus. B. Observations On 4/8/25 at 12:26 p.m. Resident #20 was sitting in his wheelchair in the activities room. Activities assistant (AA) #1 was sitting with the resident. At 12:37 p.m. AA #1 removed the splint device from the resident's contracted right hand and began to cut the fingernails on his hand. After cutting the fingernails on Resident #20's proceeded'to cut the fingernails on his left hand, put lotion on both of his hands and put the splint device back on his right hand. C. Record review A physician follow up note, dated 3/25/25, revealed Resident #20 had type 2 diabetes mellitus controlled with a diabetic diet. II. Staff interviews The activities director (AD) was interviewed on 4/9/25 at 1:42 p.m. The AD said activities staff could not trim or cut the fingernails for residents who had diabetes.'He said he could cut the nails of diabetic residents because he was a certified nurse aide (CNA). He said he was not aware AA #1 had cut Resident #20's fingernails. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #2 was interviewed on 4/9/25 at 1:56 p.m. RN #2 said CNAs could not cut diabetic fingernails because it was not in their skill set. RN #2 said diabetic residents had elevated blood sugars and did not heal well, so if a CNA cut their nails, it could put the resident at risk for wounds and infections if the CNA accidently cut the resident's skin. The director of nursing (DON) was interviewed on 4/9/25 at 2:24 p.m. The DON said the podiatrist cut the fingernails and toenails of the diabetic residents. The DON said nurses could cut diabetic residents nails but CNAs could not due to their skill set. She said if a CNA cut the nails, it could put the resident at risk for wounds and infections if the CNA accidently cut the skin. The DON was unaware the AD believed he could cut diabetic residents' nails and she was unaware'AA #1 had cut Resident #20's nails. She said she would conduct training with the staff.

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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** 46849 IV. Resident #20 A. Resident status Resident #20, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included dementia, quadriplegia, contractures of the left and right hands, diabetes and anoxic brain injury. The 3/19/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. The resident had impairments of both upper extremities, used a wheelchair to ambulate and was always incontinent of bowel and bladder. The resident was dependent on staff for eating, toileting, personal hygiene, shower, dressing and transfers. B. Resident observation During a continuous observation on 4/7/25, beginning at 11:41 a.m. and ending at 2:49 p.m., the following was observed: At 11:41 a.m. the resident was sitting in his wheelchair in the dining room. At 12:33 p.m. a staff member took the resident from the dining room to a television room. At 1:32 p.m. a staff member took Resident #20 to the activities room for an activity. At 2:49 p.m. the resident was taken back to the dining room for a different activity. -Resident #20 was not offered repositioning or toileting assistance during the over three hour continuous observation. During a continuous observation on 4/8/25, beginning at 8:54 a.m. and ending at 12:55 p.m., the following was observed: At 8:54 a.m. Resident #20 was sitting in his wheelchair in the television room. At 9:25 a.m. the resident was taken to the gym for therapy. At 10:00 a.m. Resident #20 was taken to the dining room for chair exercises. The resident remained in the dining room for the food committee, asleep in his wheelchair. At 11:40 a.m. the resident was served his lunch in the dining room. At 12:15 p.m., when the resident was finished eating, he was taken to the television room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:26 p.m. an activities assistant came and took Resident #20 to the activities room for an activity. At 12:48 p.m. registered nurse (RN) #1 came and took the resident from the activities room to the therapy gym to retrieve his incentive spirometer (lung expansion device) and then took him to his room for a breathing treatment. At 12:58 p.m., RN #1 said she was not aware Resident #20 had not been changed in almost four hours.She found a CNA to help change the resident. C. Record review Resident #20's ADL care plan, revised 8/27/24, revealed the resident had a self-care performance deficit related to impaired physical mobility due to quadriplegia and contractures. Interventions (initiated 2/18/23) included providing the resident with total assistance by two staff members for toileting. The bowel and bladder care plan, revised 5/7/24, revealed Resident #20 was at risk of skin breakdown and pressure injury development related to impaired physical mobility, bowel and urinary incontinence and requiring total assistance with bed mobility and repositioning. Interventions (initiated 2/18/23) included to encourage/assist the resident with repositioning frequently as the resident allowed. A nursing bowel and bladder assessment, dated 3/10/25, revealed the resident was incontinent, required extensive assistance with toileting and was on a two-hour check and change schedule. A physician follow up note, dated 3/27/25, revealed Resident #20 had multiple comorbidities requiring medication management that necessitated frequent clinical evaluations. Without regular monitoring and management, the resident was at moderate to high risk of symptom exacerbation and complications resulting in hospitalization or death. The resident had functional impairments with potential high risk for frequent falls, bowel or bladder complications, and new or worsening wounds and required frequent monitoring. D. Staff interviews CNA #1 was interviewed on 4/8/25 at 2:30 p.m. CNA #1 said Resident #20 required total assistance from the staff for changing after an episode of incontinence. She said he was non-verbal and could only respond to yes or no questions and if he was asked, he could express to staff if he needed to be changed. Licensed practical nurse (LPN) #1 was interviewed on 4/9/25 at 1:30 p.m. LPN #1 said Resident #20 required extensive two-person assistance with being changed after an episode of incontinence. LPN #1 said the resident was incontinent of bowel and bladder and needed to be checked on by staff every two hours to prevent skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 was interviewed on 4/9/25 at 1:45 p.m. CNA #5 said Resident #20 required total assistance from the staff for changing after an episode of incontinence. CNA #5 said the staff did not document after they had changed him, but to prevent skin breakdown, he needed to be checked on every two hours. The director of nursing (DON) was interviewed on 4/9/25 at 4:27 p.m. The DON said residents who were incontinent needed to be checked on every two hours to ensure they had not had an episode of incontinence. The DON said it was important to check on the residents at least every two hours to prevent skin breakdown which could lead to pressure injuries. The DON was not aware Resident #20 had gone three to fours hours without being changed on 4/7/25 and 4/8/25. 52094 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities for three (#5, #20 and #30) of four residents reviewed for ADLs out of 31 sample residents. Specifically the facility failed to: -Ensure Resident #5 and Resident #30 received timely meal assistance; and, -Offer timely toileting assistance and repositioning for Resident #20. Findings include: I. Facility policy and procedure The Activity of Daily Living (ADL) policy was provided by the nursing home administrator (NHA) on 4/14/25 at 1:47 p.m The policy read in pertinent part, Based on the resident`s comprehensive assessment and consistent with the resident`s needs and choices, ensure a resident`s abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following ADLs: Eating, to include meals and snacks. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. II. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the April 2025 computerized physician's orders (CPO), diagnoses included severe protein malnutrition, multiple sclerosis, dysphagia and dementia. The 1/19/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of ten out of 15. The resident required assistance with all of her ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident required supervision or touching assistance while eating. B. Observations On 4/7/25 at 12:15 p.m. Resident #5 was served her lunch meal, which consisted of ham and sweet potatoes. The ham was not cut up as directed on her meal ticket (see record review below). During a continuous observation on 4/8/25, beginning at 5:10 p.m. and ending at 5:30 p.m., the following was observed: At 5:10 p.m., Resident #5 was served a shredded steak sandwich on a hoagie roll. She picked at the shredded beef but she did not touch the bread. At 5:20 p.m., she had eaten the dessert. At 5:30 p.m., she was observed to leave the table and did not receive any assistance or encouragement to eat. She consumed less than 25% of her meal, however, staff did not offer her an alternative when she consumed less than 25% of her meal. Review of Resident #5's dinner meal documentation on 4/7/25 revealed staff documented the resident ate 25% to 50% of her meal. -However, the resident consumed less than 25% of her meal (see observation above). During a continuous observation on 4/9/25, beginning at 11:45 a.m. and ending at 12:25 p.m. the following was observed: At 11:45 a.m., Resident #5 received her lunch meal, which consisted of a bowl of cream of potato soup and a fruit tart. At 12:01 p.m., she ate the creamed broth of the soup but left the potatoes in the bowl. She additionally ate the inside of the fruit tart. Staff did not offer the resident encouragement or assistance during the meal. At 12:25 p.m., the resident left the table. She was not offered an alternative and was not offered encouragement. C. Record review Resident #5`s nutrition care plan, initiated 1/14/25, revealed the resident was at potential risk for altered nutritional status and she required assistance during meals. Interventions included cutting up the resident's meat portions and assisting the resident with meals as needed.  Review of Resident #5`s April 2025 CPO revealed a physician's order for the resident to receive verbal cueing at meals, ordered 3/22/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 4/9/25 at 9:45 a.m. CNA #7 said Resident #5 was able to feed herself. However, she said she was not a big eater. She said the resident needed prompting to eat. She said the resident was able to choose what she wanted to eat. CNA #7 said the resident's meat portions needed to be cut for her. The registered dietitian (RD) was interviewed on 4/10/25 at 2:00 p.m. The RD said Resident #5 could feed herself, however, she said she required encouragement to eat. She said staff needed to ensure they were documenting the resident's meal intake accurately. The RD said the dietary manager was to ensure an alternative meal was offered when Resident #5 consumed less than 50% of her meal. III. Resident #30 A. Resident status Resident #30, age 86, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included dementia without behavioral disturbance, anxiety and mood disturbance and hypertensive heart disease with heart failure. The 1/7/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. The resident required partial to moderate assistance with ADLs. She required set up assistance for eating. B. Observations During a continuous observation on 4/7/25, beginning at 12:15 p.m. and ending at 12:37 p.m. the following was observed: At 12:15 p.m., Resident #30 received her lunch meal, which consisted of mechanical soft ham, sweet potatoes, broccoli and a cookie. At 12:20 p.m., she was not eating her meal and had not received any encouragement. At 12:27 p.m., she was eating the cookie, she had not touched her main entree. At 12:30 p.m., the table mate was telling the resident to drink her milk. At 12:37 p.m., she pushed herself from the table and wheeled herself out of the dining room. No one stopped her to ask if she wanted an alternative meal, or to provide any encouragement to eat. During a continuous observation on 4/8/25, beginning at 5:10 p.m. and ending at 5:35 p.m. the following was observed: At 5:10 p.m., Resident #30 received her dinner meal. She received a steak sandwich, french fries and an oatmeal pie. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 5:11 p.m., the resident said she wanted the rice crispy treat which the regular diet received. The registered dietitian told her that she could not have the rice crispy treat because she was on a mechanical soft diet. The resident did not have her teeth in her mouth. At 5:20 p.m., she continued to She was not offered an alternative meal when she did not eat her meal and she was not provided any encouragement from the staff to eat the main part of her meal. At 5:28 p.m., the activity assistant stopped by the table and said hello to the residents at the table. She was not provided any encouragement to eat. At 5:35 p.m., she left the dining room with her roommate. She only consumed the oatmeal pie. During a continuous observation on 4/9/25, beginning at 11:58 a.m. and ending at 12:30 p.m., the following was observed: At 11:58 a.m., the resident received her meal, she pushed the plate away from her. She was served ice cream and she was eating the ice cream. At 12:15 p.m., she finished the ice cream. She did not receive any encouragement. At 12:20 p.m., the resident's roommate who sat at the same table encouraged the resident to drink her milk. At 12:30 p.m., the resident left the dining room. She consumed only the ice cream. C. Resident representative interview Resident #30's representative was interviewed on 4/8/25 at 9:52 a.m. The representative said Resident #30 was able to feed herself. She said Resident #30 did not receive encouragement to eat the main portion of her meals. She said the staff automatically provided the resident with an ice cream rather than a nutritional alternative to the meal, instead of waiting to see if she would eat other portions of the main meal. D. Record review Resident #30's nutrition care plan, initiated 2/13/25, identified the resident was at risk for altered nutritional status. Pertinent interventions included providing encouragement during meals. The 1/7/25 nutritional assessment revealed the resident had denture problems, she fed herself and she was missing her upper and lower dentures. -The assessment did not indicate the resident required cueing at meals. E. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7 was interviewed on 4/10/25 at 9:46 a.m. She said Resident #30 was able to feed herself, but did require assistance and encouragement. She said she liked to eat her dessert first. She said she could be resistive to assistance at times, however, different approaches should be attempted. She said the facility should find a way to incorporate more dessert-like nutritional items in the resident's diet. The RD was interviewed on 4/10/25 at 2:00 p.m. The RD said Resident #30 was reviewed quarterly. She said the resident was able to feed herself, however, she said she needed encouragement to eat. She said the resident should be encouraged to eat the main meal and offered alternatives prior to an ice cream being served.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on observations, record review and interviews, the facility failed to provide one (#30) out of five residents out of 31 residents with an ongoing program of activities designed to meet needs and interests and promote physical, medical and psychosocial well-being. Specifically the facility failed to ensure Resident #30 received a personalized activity program. Findings include: I. Resident #30 A. Resident status Resident #30, age 86, was admitted on [DATE]. According to the April 2025 computerized physician ' s orders (CPO), diagnoses included dementia without behavioral disturbance, anxiety and mood disturbance and hypertensive heart disease with heart failure. The 1/7/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required partial to moderate assistance with activities of daily living (ADL). She required set up assistance for eating. The 1/27/25 MDS assessment revealed it was very important for Resident #30 to do activities she liked such as religious activities and pets. B. Resident representative interview Resident #30 ' s resident representative was interviewed on 4/8/25 at 9:52 a.m. The representative said Resident #30 always enjoyed religious activities. She said she always attended church services. She said Resident #30 really enjoyed animals, especially dogs. She said her face lit up when she was near a dog. C.Observations On 4/8/25 at 1:47 p.m. Resident #30 was sitting in her wheelchair in her doorway. She was not involved in any meaningful activities while there was an activity going on in the Galaxy Room. A staff member stopped to talk to her for a minute. She did not get invited to the activity in the Galaxy Room. During a continuous observation on 4/9/25, beginning at 9:10 a.m. and ending at 9:55 a.m., Resident #30 was sitting in her doorway in her wheelchair. Several staff members passed her. She was not invited to participate in the exercise group that was occurring in the dining room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 4/10/25, beginning at 2:00 p.m. and ending at 2:55 p.m. Resident #30 was sitting in her wheelchair in her doorway. She was not participating in any meaningful activities. C. Record review The participation record from 3/10/25 to 4/10/25 revealed the resident was not offered any religious activities or animal visits. The activities care plan, revised on 3/25/25, revealed the resident had interests in many activities such as Bingo musical groups and bean bag toss. Pertinent interventions included reminding the resident to attend the activities and providing her with a monthly activity calendar. -The care plan failed to include that it was very important for the resident to attend religious activities and have animal visits. The 3/25/25 activity participation review documented the resident enjoyed a variety of groups and outings. The goal was to keep the resident ' s activity program the same with the resident attending groups such as socials, music Bingo and exercise type groups. -The assessment did not include the resident ' s preference of pet visits or religious activities. II. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 4/8/25. CNA #7 said Resident #30 liked to participate in Bingo and movie nights. She said Resident #30 would get angry at staff when she did not want to participate in an activity. She said staff should provide further encouragement in a different manner if Resident #30 refused to participate. The activity director (AD) was interviewed on 4/10/25 at 2:45 p.m. The AD said Resident #30 liked to participate in Bingo, [NAME] ball and shopping. The AD said Resident #30 participated in more activities some days than others. He said she liked to spend time with her roommate mostly. He said she participated in Bingo two times and all of the other activities. He said the facility tried to keep her as busy as possible. He said the goal was to get her involved with activities at least five times a week. He said she would get easily angry and would throw objects at the staff. He said activity staff should ask her to participate. The AD said she needed to be reminded and taken to activities. The AD said she would not know if there was an activity going on without being informed. The AD said staff should come back and offer activity again.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain vision abilities for one (#30) of one resident reviewed for vision out of 31 sample residents. Specifically, the facility failed to follow up on Resident #30's referral for cataract surgery. Findings include: I. Facility policy and procedure The Hearing and Vison policy, undated, was provided by the nursing home administrator (NHA) on 4/14/25 at 1:47 p.m. It read in pertinent part, The facility ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker/social service designee is responsible for assisting residents and their families in location and utilizing any available resources, for the provision of the vision services that the resident needs. Once vision or hearing services have been identified, the social worker will assist the resident by making appointments and arranging for transportation. II. Resident #30 A. Resident status Resident #30, age 86, was admitted on [DATE]. According to the April 2025 computerized physician's orders (CPO), diagnoses included dementia without behavioral disturbance, anxiety and mood disturbance and hypertensive heart disease with heart failure. The 1/27/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) with a score of three out of 15. The resident required assistance with all of her activities of daily living. The MDS assessment indicated the resident needed corrective lenses. B. Resident representative Resident #30's representative was interviewed on 4/8/25 at 9:52 a.m. The representative said Resident #30 was seen by an eye doctor in February 2025 and was supposed to have further tests done for cataract surgery. She said that had not been done. C. Record review The ancillary services care plan, initiated on 2/13/25, revealed the resident had routine ancillary needs that included optometry (eye doctor), dentistry and podiatry (foot doctor). Pertinent interventions included for the social services department to coordinate ancillary services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/18/25 optometrist report documented the resident was evaluated for cataracts with blurry vision in the right and left eye. The plan was for the resident to have a referral for cataract surgery. Review of Resident #30's electronic medical record (EMR) did not reveal documentation indicating the resident had been referred to an ophthalmologist for cataract surgery as recommended on 2/18/25. III. Staff interviews The social service director (SSD) was interviewed on 4/10/25 at 10:33 a.m. The SSD said the nurses notified her when a resident needed a vision appointment. She said when she received the referral for Resident #30 in February 2025 she gave it to the transportation staff member. She said she had not followed up on the referral. The transportation coordinator (TC) was interviewed on 4/10/25 at approximately 3:00 p.m. The TC said she had not received the referral for Resident #30's cataract surgery. She said it was accidentally missed. She said she was working on getting it scheduled.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#45) of three residents reviewed out of 29 sample residents. Resident #45 was admitted on [DATE] for long-term care with a diagnosis of bipolar (mental illness), borderline personality disorder, intellectual disability and dysphagia/oropharyngeal phase (difficulty in swallowing due to issues in the part of the throat located behind the mouth). On [DATE] Resident #45 had an episode of choking after she grabbed a handful of leftover refried beans and shoved them into her mouth before the staff could stop her and she aspirated. The resident required the Heimlich maneuver (abdominal thrusts used to remove food or particles stuck in the airway) and suctioning. The [DATE] physician's order revealed, based on assessments from the speech therapist (ST), Resident #45 required one-on-one supervision during meals, cueing for small bites/sips, slow rate, redirection to prevent wandering and an upright positioning with all oral intake. Observations during the survey revealed the one-on-one staff member did not offer Resident #45 cueing for small bites/sips, slow rate or an upright position with oral intake. Additionally, the one-on-one staff member left the resident alone during the meal. The facility's failure to ensure identified interventions for Resident #45's known choking risk were implemented consistently created the potential for serious harm for Resident #45. Findings include: I. Immediate jeopardy A. Situation of immediate jeopardy The facility failed to ensure staff provided appropriate supervision and implemented the identified care-planned interventions for Resident #45 after the resident had a choking incident on [DATE]. The facility's failure to ensure staff provided appropriate supervision and implemented care-planned interventions led to a continued risk of further choking incidents for Resident #45. B. Imposition of immediate jeopardy On [DATE] at 8:15 a.m., the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #45 received appropriate supervision during times of intake. C. Facility plan to remove immediate jeopardy (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 3:20 p.m., the facility submitted a plan to remove the immediate jeopardy, The removal plan read: 1. Corrective action On [DATE] Resident #45 was placed on one-on-one supervision to ensure continuous monitoring during mealtimes and to reduce the risk of choking. The resident will be reviewed weekly by the interdisciplinary team (IDT) to determine appropriateness of remaining on one-on-one supervision. By [DATE] an audit of all nursing staff cardiopulmonary resuscitation (CPR) certifications, specifically including verification of Heimlich maneuver training, will be completed. On [DATE], there are seven staff members who are CPR and Heimlich maneuver trained in the facility. The facility will have a minimum of one person who is CPR certified and Heimlich maneuver trained in the facility and observing meals at all times. 2. Identification of others On [DATE] all residents were screened utilizing the swallowing disorder section from their most recent minimum data set (MDS) assessment. For any residents identified as having swallowing difficulties, the IDT ensured care plans were reviewed and appropriate interventions were implemented. Communication will occur with staff by updating care plans and by updating Kardex (staff directive tool). The director of nursing (DON) or designee will perform education to all nursing staff by [DATE] or before the start of their next shift. Education will be in person by the DON or designee. 3. Systematic changes On [DATE] the DON or designee conducted in-service training on the Foreign Body Airway Obstruction policy for all currently scheduled facility and agency staff. Staff not present on [DATE] will receive education prior to the start of their next scheduled shift. On [DATE] the speech language therapist (SLP) or a designee who has been trained by the SLP, provided training to all nursing and agency staff regarding expectations when assigned as a one-on-one during meals. Training included the following key points: -The resident must not be left unattended during meals. -Staff must intervene if the resident begins to fall asleep. -Staff must implement appropriate interventions (discovered in the care plan or Kardex) if the resident exhibits unsafe eating behaviors. -Staff not trained on [DATE] will be educated prior to their next shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] the DON or designee educated nursing and agency staff on all relevant physician's orders related to Resident #45. Staff not in attendance on [DATE], will receive training before their next scheduled shift. On [DATE] the DON or designee reviewed the care plan interventions for Resident #45 with all available nursing and agency staff. Staff not trained on [DATE] will be educated before their next scheduled shift. D. Removal of immediate jeopardy The NHA was notified the immediate jeopardy was removed on [DATE] at 3:30 p.m. based on the facility's removal plan (see above). However, the deficient practice remained at a D level, no actual harm with potential for more than minimal harm that is not immediate jeopardy. II. Facility policy and procedure The Foreign Body Airway Obstruction (choking) policy, undated, was provided by the nursing home administrator (NHA) on [DATE] at 11:00 a.m. It read in pertinent part: The facility will ensure that all direct care staff and any other designated staff be trained and certified in performing CPR to include the Heimlich maneuver if a choking event/foreign body obstruction should occur. Residents should be assessed to determine if they are at a higher risk for foreign body obstruction/ choking episodes and care planned accordingly. Document the event and response to the interventions implemented. III. Resident #45 A. Resident status Resident #45, age less than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included bipolar, borderline personality disorder, intellectual disability and dysphagia/oropharyngeal phase. The [DATE] MDS assessment revealed the resident was cognitively intact with a brief interview of mental status (BIMS) score of 13 out of 15. The MDS assessment indicated the resident experienced coughing and choking during meals and had complaints of difficulty or pain with swallowing. The resident required set-up and supervision with eating. B. Resident observation and interview During a continuous observation of the lunch meal on [DATE], beginning at 11:30 a.m. and ending at 1:00 p. m. the following was observed: At 11:30 a.m. certified nurse aide (CNA) #1 was sitting next to Resident #45. The resident was served mechanical soft ham, sweet potatoes and a dinner roll. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Between 12:00 p.m. and 12:40 p.m., Resident #45 fell asleep at the table with her head back while chewing nine times. When the resident would wake up, she would continue to chew the food that was remaining in her mouth, put more food into her mouth and then fall asleep again without finishing chewing her food. CNA #1 was sitting with the resident and left her alone for two to three minutes twice, prompted her to wake up three times and did not wake the resident when she fell asleep four times. During a continuous observation of the lunch meal on [DATE], beginning at 11:30 a.m. and ending at 1:00 p. m., the following was observed: At 11:30 a.m. CNA #4 was sitting with Resident #45. At 11:55 a.m. the resident was served her lunch, which consisted of a mechanical soft riblette meat, macaroni and beans. Between 11:55 a.m. and 12:30 p.m., the resident used her hands to scoop handfuls of beans and macaroni into her mouth. The resident did not completely chew her food before putting more food into her mouth. CNA #4 reminded Resident #45 to use her silverware twice but the resident would not consistently use it. CNA #4 watched Resident #45 eat with her hands and did not cue or encourage her to take small bites/sips or to eat at a slow rate. Resident #45 was interviewed on [DATE] at 1:12 p.m. She said she was on a soft diet but she was not sure why. C. Record review The nutrition care plan, initiated on [DATE], revealed Resident #45 was at nutritional risk related to bipolar disorder, intellectual disability, dysphagia and kidney disease. Interventions initiated on [DATE] included offering fluids in between meals during snack times and speech therapy (ST) to evaluate and provide treatment as indicated. Resident #45's [DATE] CPO revealed the following physician's orders: Give thickened liquid nectar consistency for history of choking, ordered on [DATE]. Provide skilled ST 12 times for four weeks for cognitive-communication impairment and oropharyngeal dysphagia. Treatment may include education of safety precautions, education of safe swallow strategies and diet modifications, ordered on [DATE]. Regular diet: mechanical soft texture, thin liquids and double portions, ordered on [DATE]. Provide one-on-one supervision during meals, cueing for small bites/sips, slow rate, redirection to prevent wandering, and upright positioning with all oral intake, ordered on [DATE]. The dietary interview and prescreen assessment, dated [DATE], revealed Resident #45 was prescribed a regular diet, puree texture and thickened nectar liquids. The risks identified for not following the order included choking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #45's progress notes dated [DATE] through [DATE] revealed: A physician note, dated [DATE], revealed Resident #45 had an event of choking. The resident grabbed a handful of leftover refried beans and shoved them into her mouth before the staff could stop her and she aspirated. The resident required the Heimlich maneuver and suctioning. A speech therapy evaluation was ordered and the resident's diet was changed to puree texture with thin liquids. A speech therapy note, dated [DATE], revealed Resident #45 was assessed per the physician's order. A cognitive assessment was completed and the score demonstrated the resident had moderate cognitive impairments and required cueing for orientation, short term recall and problem solving. A speech therapy note, dated [DATE], revealed during an observation of meal service, the ST noted if Resident #45 did not receive cueing during the meal, she became impulsive and would take large bites and eat at a quicker rate. The ST recommended moderate verbal cues for safe swallowing strategies and a continuation of the pureed diet. A nursing note, dated [DATE], revealed Resident #45 was observed in the dining room eating food off of dining room tables from other residents' who were finished and not finished with their trays. A behavior note, dated [DATE], revealed Resident #45 was observed eating her roommate's snacks. A speech therapy note, dated [DATE], revealed Resident #45 had displayed behaviors of taking food from other residents' trays during meals. A specialized restorative program was created for supervision and cueing of the resident during meals to help encourage intake of her meal and prevent the resident from taking others food. During her session with the therapist, the resident required frequent cueing for small bites, slow rate and upright positioning. A behavior note, dated [DATE], revealed Resident #45 was observed in the dining room sticking her hand into another resident's food and then eating it. A behavior note, dated [DATE], revealed Resident #45 had obtained money from another resident and was observed trying to get a soda from a vending machine. A speech therapy note, dated [DATE], revealed Resident #45 was reassessed for swallowing functioning. Speech therapy recommended one-on-one supervision during meals with cueing for strategies and an advanced diet upgrade to mechanical soft with double portions. A speech therapy note, dated [DATE], revealed Resident #45 had been upgraded to a mechanical soft diet with thin liquids, but continued to demonstrate disorganized thought patterns and reduce safety awareness. IV. Staff interviews (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	CNA #1 was interviewed on [DATE] at 2:30 p.m. CNA #1 said Resident #45 had a one-on-one caregiver because she went into other residents' rooms and stole their snacks and cigarettes. CNA #1 said the resident needed supervision with meals because she ate too quickly and needed to be prompted to slow down. CNA #1 said if the resident fell asleep while she was eating that would put her at risk for choking. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 1:30 p.m. LPN #1 said he had worked with Resident #45 since her admission but he did not know why she had a one-on-one caregiver or why she needed supervision during meals. Registered nurse (RN) #2 was interviewed on [DATE] at 1:56 p.m. RN #2 said Resident #45 had a one-on-one caregiver because of her wandering into other resident's rooms and her risk of aspiration during meals. RN #2 said the resident was impulsive and made poor decisions in terms of eating safely, chewing completely and eating slowly. The registered dietitian (RD) was interviewed on [DATE] at 2:21 p.m. The RD said she completed annual and quarterly assessments based on the residents' MDS assessment schedule. She said if she needed to do additional assessments, the nurses would notify her. The RD said Resident #45 was originally placed on a pureed diet because the staff reported the resident choking on food. The RD said ST then evaluated the resident and upgraded her to mechanical soft textures. The director of rehabilitation (DOR), who was also a speech therapist, was interviewed on [DATE] at 2:30 p. m. The DOR said when Resident #45 admitted to the facility she was initially put on a pureed diet due to choking. The DOR said the resident was demonstrating unsafe eating due to behaviors, not physical deficits. The DOR said she assessed the resident from a behavioral standpoint and determined she was able to eat mechanical textures with cueing and prompting for safety. The DOR said the therapy department had recommended the one-on-one caregiver during meals to assist Resident #45 in developing better eating habits and monitoring her for safety. She said if the resident was sleeping while chewing, it put the resident at risk for choking and aspiration. The DOR said she was not aware that the one-on-one caregiver was not following speech therapy's recommendations for providing the resident with cues and prompts during meals. The DON was interviewed on [DATE] at 2:24 p.m. The DON said if a resident fell asleep while eating, it put the resident at risk for choking and aspiration. The DON said she was not aware that the one-on-one caregiver with Resident #45 was not adequately providing the resident with cues and prompts during meals and was not preventing her from sleeping while chewing. The NHA was interviewed on [DATE] at 2:15 p.m. The NHA said Resident #45 would continue with one-on-one staff supervision while eating until the speech therapist determined she was safe to eat independently.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#9) of three residents who required respiratory care received care consistent with professional standards of practice out of 31 sample residents. Specifically, the facility failed to follow physician's orders to maintain, clean, sanitize and store Resident #19's continuous positive airway pressure (CPAP) mask and machine. Findings include: I. Facility policy and procedure The CPAP/BiPAP support policy and procedure, revised March 2015, was provided by the nursing home administrator (NHA) on 4/14/25 at 1:47 p.m. It revealed in pertinent part, To provide the spontaneously breathing resident with continuous positive airway pressure (CPAP) with or without supplemental oxygen. General guidelines for cleaning the machine: wipe machine down with warm soapy water and rinse at least once a week and as needed. Clean humidifier weekly and air dry. Masks, nasal pillow, and tubing: clean daily by placing in warm water, soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow to air dry between uses. Head gear (strap) wash with warm water and mild detergent as needed and allow to air dry. II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO) diagnoses included obstructive sleep apnea (breathing repeatedly stops or becomes shallow during sleep due to a blockage in the upper airway), major depression disorder, dementia, Parkinson's disease (neurological disorder affecting movement), hemiplegia left side (loss of movement on one side of the body), type two diabetes (abnormal glucose control) and hypertension (high blood pressure). The 1/7/25 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. He was dependent on staff for toileting, dressing, personal hygiene, and transfers. He required set up assistance for eating. It revealed the resident had shortness of breath or trouble breathing when laying flat and used a non-invasive mechanical ventilator like CPAP or BiPAP and oxygen therapy. B. Resident interview (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 was interviewed on 4/7/25 at 2:07 p.m. He said the staff helped him put on his CPAP at night. Resident #9 said the staff cleaned the machine and pieces that went on his face with a white wipe, but he was unsure how often it was cleaned. Resident #9 said the staff put the mask and head gear into the top drawer of his nightstand after he used it and he's never seen them put it into a bag for storage. C. Observations and staff interviews On 4/7/25 at 2:07 p.m. Resident #9's CPAP tubing, mask and head gear were observed loose in the top drawer of his night stand. There was visible debris in the drawer and several personal items loose in the drawer with the CPAP mask and head gear. On 4/9/25 at 3:58 p.m. Resident #9's CPAP tubing, mask and head gear were observed loosely stored in the top drawer of his nightstand. The top drawer had several personal items loose in the drawer. On 4/10/25 at 9:00 a.m. certified nurse aide (CNA) #2 was observed in Resident #9 room. CNA #2 was looking in the top drawer of the night stand. CNA #2 said Resident #9 had a CPAP machine on his night stand that he used at night. CNA #2 said the respiratory nurse was responsible to help the resident apply it at night and remove it in the morning. CNA #2 said the mask and head gear should be stored in a bag after it was cleaned to prevent contamination. CNA #2 left Resident #9's room and returned with a clean trash bag and a container of Super Sani-wipes (germicide disposable surface wipe). CNA #2 applied gloves and took a Sani-wipe and began wiping the CPAP tube, head gear and mask with the wipe. CNA #2 then placed the tubing, mask and head gear into the trash bag she brought into the room. CNA #2 said there was a cell phone, a pair of scissors, an open bag of fresh scent cloth wipes (incontinence wipes), beads, a wooden cross and eye glass case in the drawer where the CPAP was being stored. CNA #2 then removed her gloves and washed her hands with soap and water prior to leaving Resident #9's room. -However, per the respiratory contractor's (RC) interview CPAP machines should not be cleaned with Super Sani-cloth wipes (see interview below). D. Record review The April 2025 CPOs revealed the following physician's order: Use CPAP wipe to clean the inside of the mask, use fresh clean wipe to clean the hard outer shell of mask and tubing, and a fresh clean wipe to clean the outside of the BiPAP unit, once daily for obstructive sleep apnea, ordered on 2/13/22. -Review of the resident's electronic medical record (EMR) did not indicate how the staff were supposed to store the CPAP when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The respiratory care plan, revised on 2/6/16, revealed Resident #9 had altered respiratory status/difficulty breathing related to obstructive sleep apnea and required CPAP for symptom management. Interventions included administering medications as ordered, applying the CPAP at bedtime for sleep apnea, coordinating services with the respiratory therapy, monitoring for signs or symptoms of respiratory distress and reporting to the physician, monitoring/documenting/ reporting abnormal breathing patterns to the physician and pacing/scheduling activities providing adequate rest periods. -The care plan failed to document how staff should clean and store the CPAP when not in use. III. Staff interviews Registered nurse (RN) #3 was interviewed on 4/10/25 at 9:42 a.m. She said the nursing staff had to assist Resident #9 with applying his CPAP. RN #3 said when the CPAP was not in use the mask and head gear were to be cleaned and stored in a plastic bag to keep it from getting dirty and prevent infection. RN #3 said the CPAP parts that touched the residents face should not be cleaned with Super Sani-cloth wipes because it could cause a reaction due to the chemicals in it. The infection preventionist (IP) was interviewed on 4/10/25 at 12:00 p.m. She said a CPAP machine should be cleaned daily and stored above the bed. The IP said the CPAP reservoir should be cleaned weekly and as needed with distilled water only. The IP said the face mask, head gear should be cleaned daily with mild soap and water and rinsed well and left to air dry. The IP said once dry it should be placed into a bag to prevent infection. The IP said Super Sani-cloth wipes could be used to clean the CPAP as well. RN #1 who was also the respiratory nurse was interviewed on 4/10/25 at 12:10 p.m. She said it was the responsibility of the floor nurse assigned to assist the resident in applying CPAP and removing and cleaning the CPAP after use. RN #1 said the CPAP should be cleaned with warm soapy water, rinsed and placed on a paper towel to dry. RN #1 said once the CPAP was dry it should be stored in a clean plastic bag to prevent contamination. The RC was interviewed via phone on 4/10/25 at 12:18 p.m. He said the manufacturers' recommendations for CPAP were to be cleaned with mild soap and water. He said Super Sani cloth wipes were not recommended because it could break down the plastic pieces used to create a seal for proper function. The director of nursing (DON) was interviewed on 4/10/25 at 2:32 p.m. She said the CPAP should be cleaned daily and placed into a plastic bag to prevent infection. The DON said the nurses should follow manufacturers' recommendations of mild soap and water to clean machines.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure one (#112) of one resident reviewed for dialysis care out of 31 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to ensure the resident's arteriovenous fistula (AVF) shunt was assessed on a daily basis. Findings include: I. Facility policy and procedure The Hemodialysis Catheters-Acccess and Care policy, dated February 2023, was received from the nursing home administrator on 4/11/25 at 4:03 p.m. The policy read in pertinent parts, Care of AVFs: -Keep the access site clean at all times; -Check the color and temperature of the fingers and the radial pulse of the access arm when performing routine care at regular intervals; -Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. The nurse should document in the resident's medical record every shift as follows: -Location of the catheter; -Condion of the dressing; -If dialysis was done during the shift; -Any part of report from dialysis nurse post-dialysis being given; -Observations post dialysis. II. Resident #112 A. Resident status Resident #112 was admitted on [DATE] and readmitted from the hospital on 3/30/25. According to the April 2025 computerized physician orders (CPO) diagnoses included, chronic obstructive pulmonary disease and renal kidney failure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/12/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required partial to moderate assistance with activities of daily living. The MDS assessment did not indicate the resident received hemodialysis. -However, the resident received hemodialysis. III. Record review Review of the April 2025 CPO revealed there was not a physician's order to monitor the shunt for patency. The electronic medical record (EMR) was reviewed from 3/30/25 to 4/9/25 and showed no documentation that the shunt was assessed for patency which included the thrill and bruit. The medication administration record (MAR) and the treatment administration record (TAR) for April 2025 revealed no documentation that the shunt was assessed for the thrill and bruit. The dialysis care plan, revised 11/27/24, identified the resident required dialysis related to a diagnosis of end stage renal disease. Pertinent interventions included checking shunt for bruit and palpate shunt for thrill by lightly placing fingertips over access site and feeling for vibration twice daily. The care plan directed staff to notify the medical provider if bruit was not heard or thrill or felt. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/9/25 at 3:40 p.m. LPN #1 said Resident #112 went to hemodialysis three times a week. He said the resident had a shunt port in his left upper extremity. He reviewed the EMR and confirmed there was not a physician's order to monitor and assess the AVF. LPN #1 said he had not assessed the AVF. The director of nursing (DON) was interviewed on 4/9/25 at 4:03 p.m. The DON said she reviewed the physician's orders for Resident #112 and said there was not a current order to have the AVF assessed. She said the AVF needed to be assessed each shift to ensure proper functioning. She said when the resident was readamitted the order was not reentered into the resident's EMR. She said nursing management completed audits to ensure batch orders, assessments and necessary physician's orders were completed. The regional director of clinical services (RDCS) was interviewed on 4/9/25 at 4:24 p.m. The RDCS said she would complete a MDS correction for the MDS, since Resident #112's MDS was coded incorrectly. V. Facility follow up A physician's order was obtained on 4/9/25 (during the survey) which read, Check shunt for bruit and palpate shunt for thrill by lightly placing fingertips over access site and feeling for vibration twice daily,If bruit is not heard or thrill not felt, notify medical provider. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/15 at 4:03 p.m. the facility sent additional information which showed the thrill and bruit was checked on 4/1/25, 4/5/25 and 4/8/25 on the communication forms. -However, the AVF was not consistently checked twice a day.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure residents who were trauma survivors, received culturally competent, trauma-informed care in accordance with professional stands or practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for two (#40 and #42) of four residents reviewed out of 31 sample residents. Specifically, the facility failed to: -Identify Resident #40 and Resident #42's history of trauma and identify triggers which may retraumatize them; and, -Ensure services and individualized care approaches were provided for Resident #40 and Resident #42. Findings include: I. Facility policy and procedure The Trauma Informed Care and Culturally Competent Care policy, revised August 2022, was provided by the nursing home administrator (NHA) on 4/11/25 at 3:53 p.m. It revealed in pertinent part, Purpose: to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Tramua-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid retraumatization. Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. Triggers are highly individualized. Some common triggers may include: experience a lack of privacy or confinement in a crowded or small space; exposure to loud noises, or bright/flashing lights; certain sights, such as objects; and/or, sounds, smells and physical touch. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. II. Resident #40 A. Resident status Resident #40, age 71, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included dementia with mood disturbances, major depressive disorder, traumatic brain injury (TBI) and schizophrenia (mental illness). The 3/29/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of 10 out of 15. He required maximum assistance from staff with hygiene, showering, toileting, dressing and transferring. B. Resident observation and interview An attempt was made to interview the resident on 4/7/25 at 10:32 a.m. When spoken to, the resident stared and did not respond. C. Record review The trauma informed care plan, revised 9/23/24, revealed the resident had a history of trauma related to sexual assault at a very young age by a minister and the resident would often talk about it. The resident had been involved in a car accident causing a TBI and had a history of incarceration. The care plan indicated social services referred him to a local mental health center for talk therapy to work through past traumas. Interventions (dated 8/7/23) included monitoring the resident for signs and symptoms of decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and reporting abnormal findings to the physician. The psychosocial care plan, revised 7/16/24, revealed the resident had a history of suicidal ideations. Interventions (dated 2/15/24) included sending the resident to the hospital for observation and a psychological evaluation, monitoring the resident for behavior episodes and attempting to determine underlying cause and consider location, time of day, persons involved, and situations and documenting behavior and potential causes. The March 2025 CPO revealed the following physician's orders: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abilify (antipsychotic) Tablet 10 milligram (mg)- give one by mouth for major depressive disorder with psychotic features, ordered on 11/5/24; Record episodes of the following behaviors: negative statements, crying and tearfulness. Interventions: one-on-one, position change, offer food and fluids, toileting, redirection and refer to nurse notes, ordered on 2/15/24; Sertraline (antidepressant) Capsule 200 mg, give one by mouth for major depressive disorder, ordered on 2/15/24; and, Buspirone (anti-anxiety medication) Tablet 5 mg- give one by mouth two times a day for anxiety-ordered on 3/27/25. The 7/28/23 Pre-Admission Screen and Resident Review (PASRR) level II notice of determination for MI (mental illness) evaluation and psychological assessment revealed: The PASRR Level II included the evaluation which revealed the resident had been evaluated for MI due to a qualifying diagnosis of major depressive disorder and schizophrenia. The evaluator identified several traumas to include: incarceration in 2013 for menacing, sexual abuse at the age of 14 by a religious figure, derogatory responses from a parent after learning of the sexual abuse (insinuations the resident enjoyed the abuse), motor vehicle accident resulting in traumatic brain injury, reoccurent suicidal thoughts and theft of possessions and displacement once incarcerated. The resident's menacing charges were related to threats he had made to a woman who dispersed his social security checks for decades and threats to kill a priest and [NAME] at a cathedral. The threats caused the church to close until the resident was apprehended. -There was no mention in the resident's care plan of a history of homicidal ideations nor were there behavior monitoring for suicidal or homicidal ideations. The social services social history assessment, dated 7/11/24, listed all significant life events that included transportation accident, physical abuse, sexual abuse and sudden death of a person close to him. Psychiatric follow up note, dated 3/10/25, revealed the resident was being followed due to a diagnosis of major depressive disorder, dementia with behavioral disturbance and seizures. The nurse practitioner (NP) conducting the follow up indicated the resident expressed feelings of loneliness and concerns about his seizure condition. The NP noted the resident's psychotropic medications were partially helpful in treating his condition. The NP noted the resident's recent history to include an episode of suicidal ideatons on 2/8/25 where the resident had to put on 15 minute staff checks. -A review of the resident's EMR failed to reveal the facility assessed the resident to identify potential triggers that could cause re-traumatization or behaviors towards others. D. Staff interviews (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nursing aide (CNA) #1 was interviewed on 4/8/25 at 2:30 p.m. She said the nurse management or the social worker would let the CNA's know specific behaviors and interventions for residents with behaviors. CNA #1 said she was not aware Resident #40 had a history of suicidal or homicidal ideations. Licensed practical nurse (LPN) #1 was interviewed on 4/9/25 at 1:30 p.m. He said Resident #40 had behaviors of anxiety but he did not know if the resident had specific triggers. LPN #1 said the resident did not have a history of suicidal or homicidal ideations. -However, the 7/28/23 PASRR Level II and the 3/10/25 NP note documented the resident had a history of suicidal and homicidal ideations (see record review above). LPN #1 said when the social worker wanted the staff to be aware of specific behaviors and non pharmacological interventions, there would be a physician's order with the resident specific behaviors and the individualized interventions identified for that resident. CNA #5 was interviewed on 4/9/25 at 1:45 p.m. She said she knew Resident #40 and that he had behaviors of sundowning (a neurological phenomenon that causes increased confusion and restlessness in people with dementia starting in late afternoon) but he showed these behaviors throughout the day. CNA #5 said the resident perseverated on death and believing he was dying, was confused about time and schedules and was frequently anxious. She said the resident did not have a history of suicidal or homicidal ideations, but there had been a period of time when the resident was not allowed to have plastic bags or sharp items in his room but the CNA was not sure why or exactly when. -However, the 7/28/23 PASRR Level II and the 3/10/25 NP note documented the resident had a history of suicidal and homicidal ideations (see record review above). Registered nurse (RN) #2 was interviewed on 4/9/25 at 1:56 p.m. She said Resident #40 told her he was depressed often and talked about being paranoid about things that happened to him at a previous facility (suspecting the facility of theft). RN #2 said when the resident was very depressed, he displayed behaviors of mutism (inability to speak), would just stare at the staff and not respond to them. She said she was not aware if the resident had a history of suicidal or homicidal ideations but it would be important for the care staff to know that about the resident. The social services director (SSD) was interviewed on 4/9/25 at 3:30pm. She said she reviewed the residents PASRR evaluations for past mental health history and triggers and then incorporated the information into the resident's care plan. The SSD said if there were suicidal or homicidal ideations identified in the PASRR, she would add those to the resident's care plan and put in a behavior tracking order for monitoring of suicidal and/or homicidal ideations. She said she was the one who determined what behaviors were added to behavior monitoring documentation. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said Resident #40 displayed behaviors of anxiety and perseverance on items he believed were stolen from another facility and believing he was actively dying. She said she was aware of his history of suicidal and homicidal ideations from his PASRR. She said the suicidal and homicidal ideations should be included on the resdient's care plan. She said she did not know why those behaviors were not on his care plan. The SSD said it would be helpful for the nurses and the CNAs to be aware of a resident's history of ideations in order to support the resident and be aware the resident was at higher risk. The SSD said the social worker should be notified immediately of any concerning behaviors or comments. The director of nursing (DON) was interviewed on 4/9/25 at 4:27 p.m. The DON said she was not aware of Resident #40's history. She said suicidal and homicidal ideations were important behaviors for the nurses and CNAs to be aware of to properly monitor and care for a resident. 20287 III. Resident #42 A. Resident status Resident #42, age 73, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included post traumatic stress disorder (PTSD), schizoaffective disorder, bipolar (mental illness) and history of falls. The 2/22/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The assessment indicated the resident had a diagnosis of PTSD. B. Resident interview Resident #42 was interviewed on 4/7/25 at 3:20 p.m. The residnet said she had a diagnosis of PTSD related to being raped with a weapon. She said the facility had not asked her any questions in relation to the past traumatic event. She said they just do not talk about it. C. Record review The psychosocial care plan, revised on 3/25/25, revealed the resident was at risk for decreased psychosocial well-being and adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to PTSD and a hisotry of, sexual assault (reports rape with weapon). Pertinent interventions included encouraging the resident to verbalize feelings, monitoring for signs and symptoms of decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and report abnormal findings to the physician. The 2/21/25 social history assessment did not document any information in regards to the individual support needed for the resident's diagnosis of PTSD. -Review of Resident #42's electronic medical record (EMR), revealed the facility failed to implement person-centered, non-pharmacological approaches e to meet the individual needs of Resident #42. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Further review of the resident's EMR did not reveal documentation that the facility completed an assessment to identify ways to eliminate or mitigate triggers that may cause re-traumatization of the resident. D. Staff interviews The SSD was interviewed on 4/10/25 at 10:33 a.m. The SSD confirmed Resident #42 had a diagnosis of PTSD. She said the resident was seen twice a month. She said the last visit was on 3/19/25, because the facility had a new provider. She said she was not aware of any assessment that could be completed to determine which triggers could cause re-traumatization of the resident. She said was aware of Resident #42's trauma , however she was not aware of what specific triggers would trigger a re-traumatization. The DON and the regional director of clinical services (RDCS) were interviewed together on 4/10/25 at 4:03 p.m. The DON said the resident was seen by a mental health provider. She said she reviewed the care plan and confirmed Resident #42's care plan did not have resident specific triggers and interventions which could cause re-traumatization. The RDCS said the facility started using a new assessment a month ago that could be used to assess residents for triggers specific to PTSD. She said she would ensure the SSD would complete this assessment for Resident #42.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on record review and interview, the facility failed to ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for four (#9, #13, #16 and #35) of five residents reviewed for unnecessary medications out of 31 sample residents. Specifically, the facility failed to: -Have a monthly medication review (MMR) completed for Resident #9, Resident #13, Resident #16, and Resident #35; and, -Failed to have licensed pharmacist signature on monthly medication review (MMR). Findings include: I. Facility policy and procedure The Medication Regimen Reviews policy and procedure, revised May 2019, was provided by the nursing home administrator (NHA) on 4/14/25 at 1:47 p.m. It revealed in pertinent part, The consultant pharmacy reviews the medication regimen of each resident at least monthly. The consultant pharmacist performs a medication regimen review (MMR) for every resident on the facility receiving medications. MMR are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. The goal of the MMR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MMR involves a thorough review of the residents medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities. The medication regimen and associated treatment goals involve collaboration with the resident (or representative), family members and in the interdisciplinary team (IDT). As such, the MMR includes review of the residents (or representatives) stated preference, the comprehensive care plan and information provided about risk and benefits of the medication regimen. Within 24 hours of the MMR, the consultant pharmacist provides a written report to the attending physician for each resident identified as having a non-life threatening medication irregularity. The report must contain: resident name, the name of medication, identified irregularity, and the pharmacists recommendations. The attending physician documents in the medical record that the irregularities have been reviewed and what (if any) action was taken to address it. The consultant pharmacist provides the director of nursing (DON) and the medical director with a written, signed and dated copy of all medication regimen reports. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included obstructive sleep apnea (breathing repeatedly stops or becomes shallow during sleep due to a blockage in the upper airway) major depression disorder, dementia), Parkinson's disease (neurological disorder affecting movement), hemiplegia left side (loss of movement on one side of the body), type two diabetes (abnormal glucose control) and hypertension (high blood pressure). The 1/7/25 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. He was dependent on staff for toileting, dressing, personal hygiene, and transfers. He required set up assistance for eating. It revealed the resident was on an antidepressant (mood stabilizer), anticonvulsant (anti seizure), hypoglycemic (reduces glucose) and antiplatelet (prevents blood cells from sticking) medication. The section of the MDS assessment that prompted documentation to indicate that a drug regimen review was completed was left blank. B. Record review A request was made for the February 2025 and March 2025 MMR. The regional director of clinical services (RDCS) provided documentation on 4/9/25 at 1:43 p.m. that revealed Resident #9 medications were assessed remotely by the pharmacist 2/28/25. The PH recommended to consider therapy modification and/or monitoring for toxicity of vitamin D. The DON documented she reviewed the recommendation on 3/1/25 that indicated to monitor the resident for toxicity. -However, the recommendations failed to have the physician's signature indicating the recommendation had been addressed by the physician. -The facility did not provide documentation indicating a MMR was completed for March 2025 for Resident #9. III. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included bipolar (mood disturbances), dementia, chronic obstructive pulmonary disease (COPD - abnormal oxygen exchange) and type two diabetes (abnormal glucose control). The 3/18/25 MDS assessment revealed the resident had short-term and long-term memory problems per staff assessment. He required moderate staff assistance with dressing. He required set up assistance for toileting, personal hygiene. He required supervision for transfers. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It revealed the resident was taking an antipsychotic medication. The section of the MDS assessment that prompted documentation to indicate that a drug regimen review was completed was left blank. B. Record review A request was made for the February 2025 and March 2025 MMR as they were not located in the EMR. The RDCS provided documentation on 4/9/25 at 1:43 p.m. The information indicated the residents medications were assessed on 3/28/25 and the PH had no recommendations. It documented it was reviewed by the DON on 3/1/25 on the MMR. -However, the DON reviewed the MMR 27 days prior to the completion of the MMR. -The facility did not provide documentation indicating a MMR was completed for February 2025 for Resident #13. IV. Resident #16 A. Resident status Resident #16, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included bipolar disorder, schizophrenia (mental illness) and COPD. The 12/31/24 MDS revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He required substantial staff assistance to toileting, dressing and transfers. The MDS assessment revealed the resident was on an antipsychotic, antidepressant, diuretic, opioids and hypoglycemic medications. The section of the MDS assessment that prompted documentation to indicate that a drug regimen review was completed was left blank. B. Record review A request was made for the February 2025 and March 2025 MMR as they were not located in the EMR. The RDCS provided documentation on 4/9/25 at 1:43 p.m. It documented Resident #16 medications were assessed on 3/31/25 and the PH was recommended for a risk versus benefit to be completed. It was noted by the DON on 3/1/25. -However the date DON signed was 30 days prior to the assessed date of 3/31/25. The recommendations failed to have a physician's signature. V. Resident #35 A. Resident status (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35, age less than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included catatonic schizophrenia (mood and movement abnormality), bipolar disease, dysphagia (difficulty swallowing) and hypertension. The 1/29/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He was dependent on staff for toileting, dressing, personal hygiene and transfers. He required set up assistance for eating. The MDS assessment revealed the resident was receiving an antipsychotic, antianxiety, anticoagulant and antibiotic medications. The section of the MDS assessment that prompted documentation to indicate that a drug regimen review was completed was left blank. B. Record review A request was made for the February 2025 and March 2025 MMR as they were not located in the EMR. The RDCS provided documentation on 4/9/25 at 1:43 p.m. for MMR. Resident #35 medications were assessed on 3/31/25 and the PH was recommending monitoring for toxicities for Calctrol/cholecalciferol. It was noted by the DON on 3/1/25 per the physician monitor for toxicity and address as needed. -However the date DON signed was 30 days prior to the assessed date of 3/31/25. -Additionally, the recommendations failed to have the physician's signature indicating the recommendation had been addressed by the physician. The recommendations failed to have a physician's signature. VI. Staff interviews The DON was interviewed on 4/10/25 at 2:25 p.m. She said the facility had changed pharmacy providers in January 2025. She said they were working out the particulars with them still. The DON said medications should be reviewed monthly for all residents to reduce the risk of drug interactions, reduce the use of unnecessary medications and to keep the residents safe. The PH was interviewed via telephone on 4/10/25 at 3:42 p.m. She said the consultant pharmacist who visited the facility monthly for the psychotropic medication meeting was unavailable today. The PH said medications could be reviewed monthly remotely and then the documents were sent to the facility with any recommendations. The PH said the forms that were sent to the facility did not have a pharmacy signature on the sheets. The PH said MMRs were important to ensure all medications were working as expected with no side effects. She said the MMRs were also used to make recommendations for monitoring, diagnoses and duration of medication use. The RDCS was interviewed on 4/10/25 at 4:00 p.m. She said the signature on the recommendations were the DONs. The RDCS indicated the DON placed her signature on the forms when she contacted the physician on recommendations verbally. The RDCS said it appeared the DON signed 3/1/25 on the MMR when she meant to sign 4/1/25.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on observations, record review and interviews, the facility failed to provide one resident (#30) with professional quality of care out of 31 residents. Specifically, the facility failed to ensure Resident #30 received timely dental service. Findings include: I. Resident #30 A. Resident status Resident #30, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician's orders (CPO), diagnoses included dementia, dysphagia (difficulty swallowing) and adult failure to thrive. The 1/27/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required assistance with all of her activities of daily living. The MDS assessment was not completed for the resident's dental status. -However, the resident was edentulous. B. Resident #30's representative interview The resident representative was interviewed on 4/10/25 at 1:00 p.m. The resident representative said she was notified the resident was going to see the dentist next week. She said she knew the resident was not wearing the dentures, but did not know they needed adjusting. C. Observations On 4/7/25 at 12:15 p.m. Resident #30 was eating her meal in the dining room. She was not wearing her dentures. On 4/8/25 at 1:47 p.m. Resident #30 was sitting in her wheelchair in the doorway of her room. She did not wear her dentures. On 4/8/25 at 5:10 p.m. Resident #30 was eating her meal in the dining room. She was not wearing her dentures. C. Record review (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated on 5/9/24 and revised on 10/26/24, revealed the resident had an ADL self-care performance deficit related to confusion, dementia, impaired balance and limited mobility. Pertinent interventions included the resident had all of her teeth extracted and would need dentures once as her gums healed (10/26/24). The ancillary services care plan, initiated on 2/13/25, revealed the resident had routine ancillary needs that included optometry (eye doctor), dentistry and podiatry (foot doctor). Pertinent interventions included notifying the dentist immediately to schedule a dental visit within three days if the resident reported tooth pain (2/13/25). The 12/6/24 progress note documented the residents' gums were healed. The 2/16/25 progress note documented the resident was having difficulty with chewing food with dentures. The dentures were loose and difficulty staying in place. The resident voiced some discomfort to gumlines. The registered nurse was to notify the social worker to add to the dental list for evaluation. -A review of Resident #30's electronic medical record (EMR) did not reveal any documentation that the resident had been seen by the dentist after it was reported she was having difficulties chewing food with dentures. D. Staff interview Certified nurse aide (CNA) #7 was interviewed on 4/10/25 at 9:46 a.m. CNA #4 said Resident #30 received new dentures this year. She said Resident #30 had no dentures for a long time after her teeth were extracted. She said Resident #30 did not wear her dentures all the time. CNA #7 said she thought Resident #30's dentures did not fit well and they caused the resident pain. She said the CNAs informed the nurse about the ill-fitting dentures. She said Resident #30 refused the CNA's and daughters help to put the resident's dentures in. She said the staff should try a different method, different time, or a different staff member to work with Resident #30 if she refused. Licensed practical nurse (LPN) #2 was interviewed on 4/10/25 at 11:29 a.m. LPN #2 said Resident #30 did not like wearing her dentures. She said Resident #30 stopped complaining about the dentures. She said the resident refused to wear them, even with her daughter's help. She said she did not think the resident was refusing to wear her dentures because of pain. She said she thought the resident was not used to the dentures. The social services director (SSD) was interviewed on 4/10/25 at 10:39 a.m. She said the dentist visited the facility every Tuesday. She said the dentist did not see Resident #30 on Tuesday (4/8/25). She said Resident #30 received new dentures in January 2025 and they were adjusted. She said she was not notified that the resident's dentures did not fit.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews the facility failed to ensure drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration for six residents (#5, #35, #47, #48, #49 and #53) of six resident out of 31 sample residents. Specifically, the facility failed to ensure Resident #5, Resident #35, Resident #47, Resident #48, Resident #49 and Resident #53 consistently had access to water to ensure proper hydration. Findings include: I. Professional reference According to Treas, [NAME], [NAME] (2022) [NAME] Advantage for Basic Nursing (3rd edition) page 939. The amount of water a person required varies according to the environmental humidity and temperature, activity level, age, and metabolic needs. The average adequate intake is about 2.7 liters of water per day for adult women and 3.7 liters for men. II. Resident group interview A group interview was conducted on 4/9/25 at 1:00 p.m. with six alert and oriented residents (#5, #35, #47, #48, #49 and #53), per the facility and assessments. The residents said they did not receive fresh ice water daily. The residents said they used to get fresh water passed to their rooms but no longer did. The residents said they wanted to receive ice water daily. III. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the April 2025 computerized physician's orders (CPO), diagnoses included severe protein malnutrition, multiple sclerosis (chronic disease), dysphagia (difficulty swallowing) and dementia. The 1/19/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of ten out of 15. The resident required assistance with all of her activities of daily living (ADL). B. Resident interview Resident #5 was interviewed on 4/7/25 at 1:50 p.m. Resident #5 said that she was supposed to keep hydrated, but she did not have a water pitcher. She said they did not pass water to the rooms daily. She said she would like more to drink. C. Observations (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 12:45 p.m., the resident was lying in bed. She had her meal in front of her. She received a 240 cubic centimeters (cc) glass of cranberry juice. She drank all of the cranberry juice. On 4/8/25 at 5:10 p.m., the resident received a 240 cc glass of cranberry juice. She drank the entire glass of cranberry juice. She was not provided additional beverages during the meal. On 4/9/25 at 9:00 a.m., the resident received her meal. She was provided a 240 cc glass of cranberry juice and a 240 cc glass of milk. The milk was poured into her cereal. -At 9:30 a.m., she drank all of the cranberry juice and the majority of the milk remained in the cereal bowl. She continued to not have a water pitcher in her room. On 4/9/25 at 3:49 p.m., the resident's room was observed with licensed practical nurse (LPN) #1. LPN #1 confirmed the resident had no water pitcher or bottle in her room. D. Record review The 12/3/24 nutritional risk review assessment revealed the resident was consuming an average of less than 1200 cc a day. -Review of the resident's electronic medical record revealed no assessment which indicated the resident's fluid needs. The 12/4/25 nurse practitioner note documented fluids were encouraged. The 1/6/25 nurse practitioner note documented the resident was educated to increase her water intake. The care plan, revised 2/2/25, identified the resident required assistance with meals, and has been recommended for nectar thick liquids but has signed a waiver for thin liquids. IV. Staff interview LPN #1 was interviewed on 4/9/25 at 3:49 p.m. LPN #1 said each resident needed to have a water pitcher or bottle. He said the certified nurse aides (CNA) were responsible to pass water to the residents each shift. He said Resident #5 was not able to get her own water due to her dexterity in her hands and mobility. The registered dietitian (RD) was interviewed on 4/10/25 at 2:00 p.m. The RD said she encouraged fluid intake for all residents. She said she recommended 1500 cc of fluid intake for the residents. She said she reviewed Resident #5 on a regular basis because she had nutritional risk factors. She said the resident should have a water pitcher in her room. She said she was not aware Resident #5 did not have a water pitcher. She was not sure if there were hydration rounds being offered to the residents. The director of nursing (DON) was interviewed on 4/10/25 at 3:00 p.m. The DON said it was important for the residents to receive fresh water daily. The DON said ice water was to be passed every shift.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46849 Based on observations, record review and interviews the facility failed to provide snacks in one of one nourishment rooms for residents who required bedtime snacks and residents who wanted snacks during off hours. Specifically, the facility failed to ensure residents were offered and provided nourishing snacks in accordance to their needs and preferences. Findings include: I. Facility policy and procedure The Offering/Serving Snacks policy and procedure, undated, was provided by the nursing home administrator (NHA) on 4/14/25 at 2:55 p.m. It revealed in pertinent part, It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences and requests at bedtime and on a daily basis. Dietary services staff deliver snacks to each nurses' station. The charge nurse is made aware of the delivery of snacks. Intake of snacks is documented in the medical record. The Food and Nutrition Services policy and procedure, revised October 2017, was provided by the NHA on 4/14/25 at 2:55 p.m. It revealed in pertinent part, Nourshing snacks are available to the residents 24 hours a day. II. Resident group interview A group interview was conducted on 4/9/25 at 1:00 p.m. with six alert and oriented residents (#5, #35, #47, #48, #49 and #53), per the facility and assessments. The residents said they had concerns with not receiving bedtime snacks. The group said if they wanted a snack during the day they would have to ask. The residents confirmed snacks were not offered. III. Observations On 4/7/25 at approximately 2:00 p.m. the refrigerator on the Santa Fe unit was observed to be empty and had no snacks. On 4/8/25 at 11:00 a.m., the refrigerator on the Santa Fe unit was observed to be empty. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The refrigerator in the nourishment room was observed on 4/9/25 at 3:29 p.m. The refrigerator had two cookies, two apple sauces, two yogurts and two half peanut butter sandwiches. The refrigerator was observed on 4/10/25 at 4:10 p.m. with the registered dietitian consultant (RDC) and it contained three apple sauces. During an observation in the kitchen on 4/10/25 at 6:34 p.m. an unidentified dietary aide loaded a cart with snacks to take to the locked refrigerator in the breakroom. The cart contained six puddings, ten wrapped cookies, four yogurts, four applesauces and thirty-two sandwiches. IV. Staff interviews The dietary manager (DM) was interviewed on 4/10/25 at 9:45 a.m. She said the dietary aides took the resident snacks out to the refrigerator in the locked breakroom between 6:30 p.m. and 7:00 p.m. The DM said the facility had a problem with leaving the snacks in the refrigerators on the hallways because there was a resident who would take the majority of the snacks to his room. The DM said the snacks in the breakroom refrigerator were for the certified nursing aides (CNA) and nurses to provide to the residents when the residents requested a snack after dinner. The DM said the residents could also come down to the kitchen anytime before 10:00 p.m. and request snacks. The DM said the snacks the dietary aides brought out in the evenings were sandwiches, pudding, yogurt and applesauce. The DM said the residents had a list on the wall in their rooms that included the meal times and the list of snacks. The DM said the residents who were not able to ambulate by themselves to the kitchen at night, not able to articulate to the staff they wanted a snack, or who had to find a staff member to request a snack, had limited access to obtaining snacks from the kitchen or the locked refrigerator. Certified nurse aide (CNA) #6 was interviewed on 4/10/25 at 11:30 a.m. CNA #6 said the nourishment refrigerator was where the snacks for the residents were stored. She said that they would go to the kitchen if there were no snacks in the nourishment refrigerator. The registered dietitian (RD) was interviewed on 4/10/25 at 2:00 p.m. The RD said snacks should be available at all times. She said the DM was responsible to ensure snacks were readily available. The DM was interviewed again on 4/10/25 at 6:34 p.m. She said upon observing the snacks available in relation to the number of residents in the facility, there was not a sufficient amount of snacks for the number of residents that resided in the facility. She said the kitchen would increase the amount of snacks so every resident could have more than one snack if they wanted. 20287

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 47064 Based on record review and interviews, the facility failed to ensure the facility's binding arbitration agreement contained the required components. Specifically, the facility failed to: -Ensure the arbitration agreement presented to residents contained language that provided for the selection of a venue that was convenient to both parties; and, -Provide for the selection of a neutral arbitrator agreed upon by both parties. Findings include: I. Facility policy and procedure The Binding Arbitration Agreement policy, dated November 2023, was provided by the nursing home administrator (NHA) on 4/10/25 at 3:00 p.m. The policy read in pertinent part, Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. Residents (or their representatives) have the right to make informed decisions about the important aspects of their health, welfare and safety. Arbitration agreements provide for the selection of a neutral arbitrator, which is agreed upon by both parties. A neutral arbitrator is an impartial, unbiased party decision maker, without the appearance of any conflicts of interest, contracted with and agreed to by both parties to resolve their dispute. Residents (or representatives) are given the opportunity to suggest an arbitrator and venue. If the facility disagrees with the resident's suggested arbitrator(s) and/or venue, the facility will document the reason and provide that documentation to the resident (or representative). Arbitration agreements provide for the selection of a venue that is both convenient to and suitably meets the needs of both parties. The venue will be agreed upon by both parties. When selecting a venue for consideration, 'convenience' for the resident (or representative) may be determined by his or her ability to get to the venue. II. Facility's binding arbitration agreement A copy of the facility's binding arbitration agreement was provided by the NHA on 4/7/25 at approximately 2:00 p.m. The agreement read in pertinent part, The arbitration shall be administered and conducted by a contracted provider in accordance with its comprehensive arbitrations rules and procedures. Within 15 days after a claim for arbitration is made, the demand shall be filed by the contracted provider (dispute resolution specialist) and a single arbitrator will be selected from a list provided by the named provider pursuant to its rules to conduct the arbitrations. The arbitrator shall have the jurisdiction to decide whether the claims may be arbitrated pursuant to this agreement. The hearing arising under this voluntary arbitration agreement shall be held in the county where the facility is located. (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility's binding arbitration agreement failed to include the selection of a neutral arbitrator agreed upon by both parties and failed to contain language that provided for the selection of a venue that was convenient to both parties. III. Staff interviews The social services assistant (SSA) was interviewed on 4/10/25 at 2:49 p.m. The SSA reviewed the arbitration agreement and said the facility's arbitration agreement did not include information indicating a resident could speak with federal, state and local surveyors or ombudsman. He said the information was included in the facility's admission agreement (a separate document) instead. The SSA said there was no language in the facility's arbitration agreement regarding a selection of venue by both parties or a neutral arbitrator agreed upon by both parties. The SSA said he was trained on the arbitration agreement for the past month. He said he had not had any residents refuse to sign the arbitration agreement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47064 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to personal funds, survey results, bedholds, re-admissions, PASSAR recommendations, quality of care, activities of daily living, activities, ancillary services, accidents/hazards, respiratory, dialysis, mental/psychosocial concerns, drug regimen, dental, hydration, snacks, arbitration, immunizations, safe and comfortable environment. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) plan, revised April 2014, was received from the nursing home administrator (NHA) on 3/8/25 at 1:09 p.m. It revealed in pertinent part, The facility shall develop, implement and maintain an ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. The object of the QAPI plan is to: -Provide means to identify and resolve present and potential negative outcomes related to resident care and services; -Reinforce and build upon effective systems and processes related to the delivery of quality care and services; -Provide structure and process to correct and identify quality and/or safety deficiencies; -Establish and implement plans to correct deficiencies,; -To monitor the effects of these action plans on resident outcomes; -Help departments, consultants, and ancillary services that provide direct care or indirect care to residents to communicate effectively; -To delineate lines of authority, responsibility and accountability; and, -Provide means to centralize and coordinate comprehensive QAPI program, as basis for demonstrating that there is an effective ongoing program. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The QAPI committee shall oversee implementations of the QAPI plan. A QAPI coordinator shall coordinate QAPI committee activities including documentation. The committee shall meet monthly to review reports, evaluate the significance of data and monitor quality related activities of all departments, services or committees. The QAPI committee shall oversee authorized QAPI activities including data collection tools, monitoring tools, and the basis for appropriateness and effectiveness of the QAPI activities. The community shall approve any corrective actions including changes in the policy and our procedures, employee practices standards of care and shall also monitor all corrective activities for appropriateness and or the need for alternative measures. The committee may recommend ways to reinforce and expand identified positive approaches and outcomes to various departments or services. Individual departments or services shall develop quality indicators for programs and services in which they are involved and which affect their function. II. Cross reference citations Cross reference F567 management of funds: The facility failed to ensure resident accounts were updated with the current facility name. Cross reference F577 right to survey results: the facility failed to have state inspections readily available and up to date. Cross reference F625 notice of bed hold policy: The facility failed to provide residents or POA bed hold information at time of transfer. Cross reference F626 permitting residents to return to the facility: The facility failed to re-admit residents after a hospital transfer. Cross reference F644 coordination of preadmission admission screening and resident review (PASRR): The facility failed to ensure PASRR recommendations were followed for specialized services. Cross reference F659 quality of care: The facility failed to ensure qualified staff provided nail care for residents with diabetes. Cross reference F677 activities of daily living (ADL) care for dependent residents: The facility failed to ensure dependent residents received assistance with ADLs. Cross reference F679 activities meet interests/needs of each resident: The facility failed to ensure residents had a personalized activity program. Cross reference F685 treatment and services to maintain hearing/vision: The facility failed to ensure residents received timely services for ancillary services. Cross reference F689 accident hazards: The facility failed to supervise a resident who was a choking risk during meals. Cross reference F695 respiratory care: The facility failed to properly clean and store a continuous positive airway pressure (CPAP) machine. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross reference F698 dialysis: The facility failed to ensure physician's orders were in place for bruit and thrill for a resident receiving dialysis. Cross reference F699 trauma informed care: The facility failed to identify triggers that could cause re-traumatization. Cross reference F756 drug regimen review: The facility failed to ensure monthly medication reviews (MMR) were completed. Cross reference F791 dental services: The facility failed to ensure residents received timely dental services. Cross reference F807 hydration: The facility failed to ensure residents were provided adequate hydration. Cross reference F809 snacks at bedtime: The facility failed to ensure residents were offered snacks at bedtime. Cross reference F848 arbitration agreements: The facility failed to provide the arbitration agreement that was presented to residents contained language that provided for the selection of a venue that was convenient to both parties. Cross reference F883: immunizations: the facility failed to notify the power of attorney (POA) of immunization administration. Cross reference F921 safe/functional/sanitary/comfortable environment: the facility failed to ensure the communal resident shower was kept clean and sanitary. III. Staff interviews The NHA was interviewed on 4/10/25 at 6:52 p.m. He said the QAPI committee met once monthly. He said the QAPI committee looked at eight to ten areas on a monthly basis. The NHA said this meeting was used to discuss new identified concerns within the facility by reviewing resident council minutes, grievances, identified trends and incidents. The NHA said once an identified area was identified the committee assessed the situation to find a root cause. The NHA said it was his responsibility to follow up on identified areas and put a performance improvement plan (PIP) in place. The NHA said the PIP would then be discussed at the next meeting to ensure there was progress in a positive manner. The NHA said the QAPI committee had not identified any concerns when it came to: meal assistance, hydration, choking hazards, dialysis, discharges, re-admission, personal funds and posted survey results. The NHA said infection control was discussed at all QAPI meetings. He was not aware there was an issue with continuous positive airway pressure (CPAP) machines cleaning until it was identified during the survey. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the facility had issues with snacks about six months ago and changed how the snacks were being distributed due to residents hoarding snacks. He said he became aware that there were not enough snacks available to residents during the survey. The NHA said the facility was not aware that the pharmacy medication reviews were not occurring monthly reports until it was brought to attention during the survey.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for one (#30) of five residents reviewed for immunizations out of 31 sample residents. Specifically, the facility failed to ensure consent was obtained from Resident #30's representative prior to administering the pneumococcal vaccination. Findings include: I. Resident #30 A. Resident status Resident #30, age 86, was admitted on [DATE]. According to the April 2025 computerized physician's orders (CPO), diagnoses included dementia without behavioral disturbance, anxiety and mood disturbance and hypertensive heart disease with heart failure. The 1/7/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required partial to moderate assistance with ADLs. The MDS assessment indicated the resident was not up to date on the pneumococcal vaccine because it was offered and declined. B. Resident representative interview Resident #30's representative was interviewed on 4/8/25 at 9:52 a.m. The representative said she was not notified and did not give consent for Resident #30 to receive the pneumococcal vaccination prior to the administration of the vaccine. She said she had taken Resident #30 out for a visit and Resident #30 complained of her arm hurting as she had received a vaccination. The representative said she called the facility and the nurse confirmed the resident received the Prevenar 20 vaccination. C. Record review Review of Resident #30's electronic medical record (EMR) revealed the resident received the Prevnar 20 immunization on 3/26/25. The resident vaccination consent for vaccinations, dated 3/21/25, revealed the consent was signed by the infection preventionist (IP). The consent form was for the pneumococcal (Prevenar 20). The consent documented, I have authority to complete this registration process and to make my health care decisions (or the healthcare decisions for the named patient). I have been given online links/documents to read about the disease and vaccines. I believe I understand the benefits and risks of the vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's EMR failed to show the resident's representative was notified or gave consent for the administration of the pneumococcal vaccination. II. Staff interviews The director of nursing (DON) was interviewed on 4/10/25 at 1:52 p.m. The DON said the IP was responsible to maintain the immunization records and ensure the residents received the immunizations if needed. She said she reviewed Resident #30's record and confirmed the IP incorrectly signed the consent for Resident #30's pneumococcal vaccination. She said the responsible party was to sign the consent and to give permission for the vaccination. She said she would provide education to the IP.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46849 Based on observations and interviews, the facility failed to provide a safe, sanitary, functional and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the residents' shower room was maintained in a safe and sanitary condition. Findings include: I. Observations On 4/8/25 at 2:13 p.m. the facilities shower room was observed. There was black residue on the surface of the grout lines going around the perimeter of the inside of the shower. II. Resident representative Resident #30's representative was interviewed on 4/8/25 at 9:43 a.m. She said the shower room was not clean and needed to have a good cleaning. She said it had been like that for some time. III. Staff interviews and observations The shower room was observed with the maintenance director (MTD) and the nursing home administrator (NHA) on 4/8/25 at 2:45 p.m. The MTD said the housekeeping staff cleaned the shower daily and deep cleaned the shower once a week. The MTD said the black residue could be soap (however the liquid body soap in the shower room was orange) or it could be splattered caulking (the caulking in the shower was gray). The MTD and the NHA said they were unable to identify the black residue so they requested a comprehensive mold test The MTD was interviewed again on 4/8/25 at 3:35 p.m. He said he had a professional commercial shower sanitizer . He said he was not able to test for mold, only sanitize the shower. The MTD was interviewed again on 4/8/25 at 4:00 p.m The MTD said the facility was able to schedule testing with an environmental testing company for the following morning. IV. Facility follow up On 4/14/25 at 9:22 a.m. the NHA provided the results from the mold tape inspection via email. The report included the observations of potential water damage, potential visual growth and excessive humidity and moisture in the shower. The laboratory results revealed common allergens were present but no fungal growth.