STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	4001 Home St Castle Rock, CO 80108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations and interviews, the facility failed to provide a comfortable and homelike environment for eight of 36 rooms. Specifically, the facility failed to provide residents with hand towels on a daily basis. Findings include: I. Facility policy and procedure The Homelike Environment policy and procedure, revised February 2021, was provided by the nursing home administrator (NHA) on 4/3/25 at 7:50 p.m. It read in pertinent part, Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. II. Observations On 3/31/25 the following observations were made: -At 1:45 p.m. room [ROOM NUMBER], a shared room, had no towels; and, -At 1:52 p.m. room [ROOM NUMBER], a shared room, had no towels. On 4/1/25 the following observations were made: -At 9:21 a.m. room [ROOM NUMBER], a shared room, had no towels; -At 9:21 a.m. room [ROOM NUMBER], a shared room, had no towels; -At 11:00 a.m. room [ROOM NUMBER], a shared room, had no towels;; -At 11:00 a.m. room [ROOM NUMBER], a shared room, had no towels; -At 11:00 a.m. room [ROOM NUMBER], a shared room, had no towels; and, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:00 a.m. room [ROOM NUMBER], a shared room, had no towels. III. Resident interviews One of the residents who resided in room [ROOM NUMBER] was interviewed on 3/31/25 at 2:01 p.m. The resident said the facility did not provide him with towels. He said he had to use his own clothing to dry his hands due to the lack of towel availability. One of the residents who resided in room [ROOM NUMBER] was interviewed on 4/1/25 at 9:21 a.m. The resident said the facility did not provide him towels for his room. IV. Staff interviews The NHA and the director of nursing (DON) were interviewed together on 4/3/25 at 4:15 p.m. The DON said towels for residents were always available in the laundry room and the facility also kept towels in the shower rooms and linen closets. The DON said the certified nurse aides (CNA) were responsible for delivering the towels to the residents daily and replacing them as needed. The DON said the CNAs had previously received education regarding providing towels to residents daily. The DON said the facility would again provide education to ensure that staff consistently met this responsibility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on record review and interviews, the facility failed to ensure two (#15 and #42) of five residents out of 30 sample residents were kept free from abuse. Specifically, the facility failed to: -Ensure Resident #15 was kept free from physical abuse by Resident #13; and, -Ensure Resident #42 was kept free from physical abuse by Resident #58. Findings include: I. Incident of physical abuse between Resident #13 and Resident #15 on 1/15/25 A. Facility investigation The 1/15/25 facility abuse investigation, documented at 2:00 p.m., revealed that Resident #13 was ambulating with his front wheel walker when Resident #15, who was seated, reached out and touched or grabbed Resident #13's left wrist. Resident #13 asked Resident #15 to let go. When Resident #15 did not let go, Resident #13 grabbed Resident #15 by the back of his neck, shook him and told him not to touch him. The staffing coordinator (SC) witnessed the incident. The SC immediately separated the residents and reported the incident to the nursing home administrator (NHA). The director of nursing (DON) assessed Resident #15's neck and observed no injury. The investigation documented Resident #15 had severe dementia and would reach out and grab things and people at times. Resident #13 was interviewed by the NHA and the DON following the incident. Resident #13 said, Oh sure, he would say that when told the incident had been reported. When the staff explained that someone else witnessed the incident, Resident #13 said, I was walking by and he grabbed my arm. I don't like that, so I grabbed his neck. The investigation documented the SC provided a written witness statement. The SC said she was coming out of her office when she saw Resident #15 in his doorway and Resident #13 was walking by. She said Resident #15 reached out and grabbed Resident #13's left wrist. She said Resident #13 shouted, Don't touch me and then grabbed Resident #15 by the neck and shook him with his right hand. The SC said she went over and separated them. She said when she separated the residents, Resident #15 struck her. The SC said Resident #13 responded, He grabbed me and I don't like that. The investigation documented the facility determined Resident #13 did shake the neck of Resident #15. The intervention included having the activities department and therapy assess different items Resident #15 could hold to help decrease his reaching out, as he was very tactile at that time. Resident #13 was educated to walk away or ask for help in these situations and that grabbing and shaking people was not acceptable. The facility added physical aggression to Resident #13's care plan. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation concluded the abuse was substantiated as the action by Resident #13 was willful. B. Resident #15 - victim 1. Resident status Resident #15, age 83, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included dementia, Alzheimer's disease and cognitive communication deficit. The 1/16/25 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory impairment and required substantial assistance with decisions regarding tasks of daily life, per staff assessment. The MDS assessment revealed the resident did not display physical behaviors directed towards others during the assessment period. 2. Record review The behavioral care plan, initiated 8/5/23 and revised 1/27/25, documented Resident #15 had a history of involvement in physical altercations with other residents, both received and initiated. It indicated Resident #15 had impaired cognitive functioning and impaired thought processes related to dementia and struck out if startled and became agitated if overstimulated. Pertinent interventions included monitoring and recording the occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate responses to verbal communication, and violence or aggression toward staff or others and taking the resident to a quieter area and away from other residents if he became agitated due to overstimulation. C. Resident #13 - assailant 1. Resident status Resident #13, age 75, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included Parkinson's disease (a disease that causes involuntary movements). The 1/12/25 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required partial to moderate assistance from one staff member with toileting, dressing and personal hygiene. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavioral care plan, initiated 8/13/24 and revised 1/21/25, documented the resident had a history of episodes of declining medications and care despite education. It documented the resident exhibited unprovoked verbally and physically aggressive behavior toward others at times. Pertinent interventions included assisting the resident to develop more appropriate methods of coping and interacting, encouraging the resident to express his needs and feelings appropriately, explaining and reinforcing to the resident why the behavior was inappropriate or unacceptable, intervening as necessary to protect the rights and safety of others, approaching and speaking to the resident in a calm manner, diverting the resident's attention, removing the resident from the situation and taking the resident to an alternate location as needed. II. Incident of physical abuse between Resident #42 and Resident #58 on 12/28/24 A. Facility investigation The 12/28/24 facility abuse investigation, documented at 6:58 p.m., revealed Resident #42 and Resident #58 were in the television common room when they began loudly arguing and yelling at one another. Resident #42 told Resident #58 to shut up and go away. Resident #58 attempted to push Resident #42's wheelchair, but instead pushed the resident directly, causing him to fall from the wheelchair onto the floor. Resident #42 landed on his right side and sustained two small skin tears to his right forearm. Staff immediately separated the residents and returned each resident to their respective room. Resident #42 was assessed by the registered nurse (RN) on duty, who provided first aid treatment to the skin tears that were sustained to the right forearm. Resident #42 later developed bruising to his right hip and buttock area. The facility notified the physician, the family members, the DON, the NHA, the police and the ombudsman. Resident #42 was upset, but reported he was not afraid of Resident #58. Resident #58 said he was trying to push Resident #42's wheelchair away and did not realize his strength. Resident #58 had a history of verbal aggression toward staff when told he could not go home but typically calmed when reminded he was staying at the facility short-term before moving to his son's house. The facility substantiated the physical abuse of Resident #42 by Resident #58, which resulted in two skin tears. B. Resident #42 - victim 1. Resident status Resident #42, age 80, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included weakness, abrasion of lower back and cognitive communication deficit. The 12/21/24 MDS revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. The resident required partial to moderate assistance from one staff member with showers. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment documented the resident did not display physical behaviors directed towards others during the assessment period. 2. Record review The 1/2/25 head-to-toe skin assessment revealed the resident had existing bruises on the right hip and buttock. The assessment also revealed an existing skin tear on the right forearm, which was covered with a dry dressing and showed no signs or symptoms of infection. C. Resident #58 - assailant 1. Resident status Resident #58, age 78, was admitted on [DATE] and discharged on [DATE]. According to the January 2025 CPO, diagnoses included dementia with other behavioral disturbances, multiple sclerosis and hearing loss. The 1/22/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. The resident required substantial assistance with oral hygiene, dressing, transferring, and toileting. The MDS assessment indicated the resident had verbal behaviors directed towards others. III. Staff interviews The DON and the NHA were interviewed on 4/3/25 at 4:15 p.m. The NHA said that as soon as an abuse situation was identified, the staff should separate the residents to ensure their safety. She said the facility staff should immediately notify the NHA and the DON so that the investigation could begin promptly. The DON said Resident #15, who often reached out toward others, grabbed Resident #13's arm as Resident #13 passed by. The DON said Resident #13 asked Resident #15 not to touch him. The DON said when Resident #15 did not respond appropriately, Resident #13 grabbed Resident #15 by the back of his neck. She said Resident #13 later admitted he should not have reacted that way. The NHA said the facility substantiated physical abuse by Resident #13 toward Resident #15. She said Resident #13 was willful in his actions. The NHA said Resident #58 was at the facility for a short respite stay. The DON said Resident #58 and Resident #42 got into a verbal altercation in the common room and Resident #42 told Resident #58 to shut up and go away. The DON said Resident #58 attempted to push Resident #42's wheelchair but instead pushed Resident #42, causing him to slide out of his chair and sustain two skin tears to his right arm. The DON said that Resident #58 admitted to pushing Resident #42 out of his chair. The DON said the incident was substantiated as Resident #58 was willful in his actions.

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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 52288

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 one (#24) of three residents out of 30 sample residents.

Specifically, the facility failed to provide timely toileting assistance or incontinence care for Resident #24.

Findings include:

I. Resident #24

A. Resident status

Resident #24, age 77, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), cognitive communication deficit and unsteadiness on feet.

The 2/27/25 minimum data set (MDS) assessment revealed the resident had severe impairment in making decisions regarding tasks of daily life, per the staff assessment for mental status. He required substantial assistance with oral care, personal hygiene, toileting, bathing, dressing and transferring.

B. Observations

During a continuous observation on 4/1/25, beginning at 1:08 p.m. and ending at 4:50 p.m., the following was observed:

At 1:08 p.m. Resident #24 was lying on the bed in his room, sleeping.

At 1:13 p.m. an unidentified staff member entered the resident's room and removed his lunch tray.

At 4:16 p.m. two unidentified staff members entered Resident #24's room. The staff members asked if Resident #24 wanted the television turned on and if he preferred the window to be closed. The staff members turned on the television and exited the room.

-Staff did not check Resident #24 for incontinence or provide toileting assistance to the resident during the nearly four hour continuous observation.

During a continuous observation on 4/2/25, beginning at 8:25 a.m. and ending at 2:10 p.m., the following was observed:

At 8:25 a.m. Resident #24 was eating breakfast in the dining room.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:00 a.m. the resident was taken from the dining room to the common area to watch television, with a pillow on his lap and his right arm resting on the pillow. At 9:22 a.m. an unidentified staff member wheeled Resident #24 to the indoor gardening activity. -Resident #24 was not checked for incontinence or offered any toileting assistance prior to being taken to the activity. At 11:54 a.m. an unidentified staff member wheeled Resident #24 to the chapel for lunch. -The resident was not checked for incontinence or offered toileting assistance prior to being taken to lunch. At 12:40 p.m. Resident #24 finished eating lunch and was wheeled to his room by certified nurse aide (CNA) #1 and assisted to bed. -CNA #1 did not check the resident for incontinence or offer toileting assistance after lunch. At 12:45 p.m. Resident #24 was sleeping in bed. At 2:02 p.m. Resident #24's skin was observed with CNA #1. CNA #1 said Resident #24 was soiled with urine and had a bowel movement. CNA #1 provided incontinence care and changed the resident's brief at that time. -Resident #24 went over five hours without being checked for incontinence or being offered toileting assistance. C. Record review The ADL care plan, updated 6/3/24, documented Resident #24 had self-care deficits related to decreased mobility, limited range of motion, a mild right hemiparesis and a cognitive deficit. The resident required supervision and cueing with ADLs. Pertinent interventions included offering and providing assistance with toileting and incontinence care per protocol, conducting routine skin checks per protocol and providing incontinence care promptly after incontinence episodes. According to the CNA task documentation for bladder incontinence, Resident #24 received incontinence care on 4/22/25 at 9:00 a.m. -However, a continuous observation of the resident conducted at that same time revealed the resident was in the common area watching television (see observations above. III. 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 #1 was interviewed on 4/2/25 at 2:02 p.m. CNA #1 said Resident #24 required a pivot transfer. He said he was able to transfer Resident #24 pretty quickly. He said Resident #24 was incontinent and required assistance with incontinence care. He said Resident #24 should be checked every two hours and changed when needed. He confirmed Resident #24 was soiled with urine and a bowel movement when he provided incontinence assistance at 2:02 p.m. after not being checked or changed for over five hours. The director of nursing (DON) was interviewed on 4/3/25 at 4:15 p.m. The DON said facility staff should conduct rounds on residents approximately every two hours. The DON said during these rounds, each resident should be checked to determine if they had an episode of incontinence. She said if a resident was found to be incontinent, staff should offer incontinence care to the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51915 Based on observations, record review and interviews, the facility failed to ensure one (#12) of one resident with limited range of motion received appropriate treatment and services out of 30 sample residents. Specifically, the facility failed to: -Develop a comprehensive care plan for Resident #12's left hand contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints); and, -Ensure Resident #12 was provided the recommended preventive measures for contracture management of her left hand. Findings include: I. Facility policy and procedure The Resident Mobility and Range of Motion policy and procedure, dated July 2017, was provided by the nursing home administrator (NHA) on 4/3/25 at 4:30 p.m. It revealed in pertinent part, Residents will not experience an avoidable reduction in range of motion (ROM), residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM, residents with limited mobility will receive appropriate services, and equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts, and the care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. II. Resident #12 A. Resident status Resident #12, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included left hemiplegia (paralysis on one side of the body) following cerebral infarction and a contracture of the left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/20/25 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. She required maximum assistance with transfers and bed mobility and moderate assistance for bathing, toileting, dressing and personal hygiene. The MDS assessment indicated Resident #12 was part of the range of motion program, which included passive range of motion and splint or brace assistance. It indicated the resident had had zero days of therapy during the seven-day look-back assessment review period. B. Resident interview and observations Resident #12 was interviewed on 4/1/25 at 10:02 a.m. Resident #12 said her left hand was contracted due to a previous stroke. She said the facility did not provide her with any therapy services, braces or other preventative measures for her left hand contracture. Resident #12's left hand was contracted with her wrist and four fingers flexed and her thumb extended against the other fingers. The resident did not have a brace or other devices on her left hand to help prevent the contracture from worsening or causing skin breakdown on her hand. On 4/2/25 at 3:20 p.m. Resident #12 was in bed. Her left hand was contracted and she was not wearing a palm guard or brace on her hand. On 4/3/25 at 11:22 a.m. Resident #12 was in bed. Her left hand was contracted and she was not wearing a palm guard or any other device on her hand. C. Record review Review of the 4/20/23 occupational therapy (OT) plan of treatment for Resident #12 documented the OT recommended wearing a palm guard on her left hand for up to eight hours every day. A review of Resident #12's electronic medical record (EMR) did not reveal documentation that Resident #12 was placed on a program to wear a palm guard for eight hours per day, which was the recommendation of the occupational therapist. -Review of Resident #12's comprehensive care plan failed to reveal a care plan focus for Resident #12's left hand contracture or any documented preventative measures and interventions. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/3/25 at 2:14 p.m. CNA #1 said Resident #12 had difficulty with her left hand due to paralysis. He said he thought she had used a device for her hand, but he said he had not seen it in over a month. He said Resident #12 was unable to move her left hand, so he helped her clean her hand. Registered nurse (RN) #1 was interviewed on 4/3/25 at 2:31 p.m. RN #1 said she was unaware of Resident #12's left hand contracture or any preventative measures put in place for the contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 4/3/25 at 3:16 p.m. The DOR said each therapist provided verbal training for any ongoing programs for contracture management after therapy had completed the residents' treatment plans. She said the facility did not have a formal way of tracking the contracture management program to ensure staff were following the therapists' recommendations. She said it was important the therapists' recommendations were followed to ensure residents' contracture did not worsen. The DOR said the occupational therapist recommended Resident #12 be provided a palm protector which should be worn eight hours per day. She said she was not sure if that recommendation was being followed. She said she would reassess Resident #12 to ensure her contracture had not worsened and provide additional education to the staff regarding the recommendations. -The facility did not provide documentation of Resident #12's initial contracture measurements prior to the survey exit to see if the resident's contracture had worsened. The NHA and the director of nursing (DON) were interviewed together on 4/3/25 at 4:18 p.m. The DON said the facility had several residents who required a contracture management program. She said the contractures should be identified in the comprehensive care plan with the preventative measures. She said the preventative measures should be identified in the CNA documentation system to ensure the CNAs provided the care that was recommended by the occupational therapist. The NHA confirmed Resident #12 had a left hand contracture. She said the resident's contracture was not identified in the comprehensive care plan and the palm protector recommendation was not part of the care documented for Resident #12. The NHA said the facility did not have a tracking system in place to ensure residents were receiving the preventative measures of their recommended contracture management program.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51915 Based on record review and interviews, the facility failed to ensure one (#259) of three residents reviewed for accidents out of 30 sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to identify the root cause of Resident #259's falls and implement effective person-centered interventions. Findings include: I. Facility policy and procedure The Fall Management policy and procedure, dated June 2022, was provided by the nursing home administrator (NHA) on 4/3/25 at 4:30 p.m. It revealed in pertinent part, A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, such as a resident pushing another resident, whether the event was witnessed or unwitnessed. The facility assists each resident in maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and functional programs, as appropriate, to minimize the risk for falls. When a resident is found on the floor, the facility is obligated to investigate to determine how the resident got there and put into place an intervention to minimize it from recurring. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred. The IDT (interdisciplinary team) designee will discuss recommended significant changes to the care plan to minimize repeat falls with the resident and/or resident's representative. The care plan will be reviewed as indicated. II. Resident #259 A. Resident status Resident #259, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included Parkinson's disease, vascular dementia without behavioral disturbance, neurocognitive disorder with [NAME] bodies, major depressive disorder and moderate protein-calorie malnutrition. The 11/29/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He required maximum assistance of one person with showering, toileting, transfers and personal hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment documented Resident #259 did not have hallucinations, delusions or physical behavioral symptoms directed toward others during the assessment period. B. Record review The activities of daily living (ADL) care plan, initiated and revised on 1/13/25, documented the resident had a self-performance deficit related to weakness, history of falling, dizziness, vascular dementia and Parkinson's disease. The interventions included working with hospice to ensure the resident maintained his current level of function, providing staff assistance of one person with bed mobility and transfers and moderate assistance with toileting. The fall care plan, initiated 2/8/24 and revised 3/31/25 (during the survey process), documented Resident #259 had a history of falls and an actual fall risk due to poor safety awareness, unsteady gait, poor comprehension and communication. The interventions included installing an anti-rollback device on his wheelchair (4/20/24), encouraging ground activities for stimulation and distraction (3/21/24), eyeballing the resident whenever going by to ensure he was not getting restless or did not require assistance (8/26/24), providing an activity basket/bag for engagement (9/25/24), providing a low bed and fall mat (2/19/24), therapy evaluation as needed (2/19/24) and conducting medication evaluation for restlessness and agitation by the resident's physician (3/12/25). The 1/2/25 physician's progress note documented Resident #259 was seen while sitting in the dining area, alert and in no distress, however he appeared quite weak. The facility staff had not reported any new issues or problems. The 3/11/25 nursing progress note, documented at 5:53 a.m., revealed Resident #259 was found in the hallway with his back against the floor, his legs extended out and his arms resting on his left and right side. Resident #259 was assessed by a registered nurse (RN) who observed a front right thigh skin tear and a small superficial scrape on his left elbow. -Review of Resident #259's care plan and electronic medical record (EMR) did not reveal any immediate interventions put into place after the resident's 3/11/25 sustained fall with injuries. The 3/11/25 hospice nursing progress note documented Resident #259 had a fall the previous night with a skin tear to the left forearm and left hip. Staff reported the resident had hallucinations, however, the resident did not report this himself. The resident said he was not aware of wakefulness or any hallucinations. The hospice nurse recommended adding Seroquel at night to attempt to assist with Resident #259's wandering and restlessness. -However, a review of the resident's EMR did not indicate episodes of restlessness or agitation until after the falls occurred. Cross reference F758 for failure to ensure there was adequate justification prior to the prescription and administration of a psychotropic medication for Resident #259. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/12/25 physician's progress note documented the physician saw Resident #259 in the hallway and he was confused and pleasant, ambulatory and seemed fairly steady. However the resident had a fall with some skin tears the night before last. It indicated the staff were not reporting any other issues. The 3/13/25 progress note, documented at 6:04 p.m., revealed Resident #259 was found in the hallway, lying down on the floor. The resident was not able to state what happened. A hematoma (bruise) was observed on the left side of his forehead and he had small skin tears on both hands. The facility contacted Resident #259's physician to evaluate medications for restlessness and agitation. The 3/13/25 IDT review documented Resident #259 had an unwitnessed fall and was found in the hallway, lying down. The resident was unable to give a statement about what happened. The intervention included the physician was to review all medications for restlessness and agitation. -However, a review of the resident's EMR did not indicate episodes of restlessness or agitation until after the falls occurred. The 3/14/25 nurse practitioner progress note documented Resident #259 had a fall on the evening of 3/13/25 resulting in a large hematoma to his left forehead and eye. Hospice suggested Seroquel nightly. The 3/16/25 nursing progress note, documented at 11:55 p.m., revealed Resident #259 was observed in the hallway, lying on the floor beside his wheelchair. The resident reported a skin tear to his right forearm and was assisted back to the wheelchair by two staff members. The resident was taken to the nursing station to watch television and be supervised by staff. The 3/20/25 IDT review documented the resident sustained two falls. The recommendation was for hospice to come and evaluate the resident for noted increased restlessness and agitation. Hospice started the resident on Seroquel 50 milligram (mg) at night. -However, a review of the resident's EMR did not indicate episodes of restlessness or agitation until after the falls occurred. -A review of the resident's EMR on 4/2/25 did not reveal documentation that the facility had identified the root cause of Resident #259's restlessness, there were not any non-pharmacological interventions put into place by the facility and there was no documentation or care plan to indicate the resident had any hallucinations or behavioral concerns to justify the immediate use of the Seroquel following Resident #259's falls. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/3/25 at 1:45 p.m. CNA #1 said Resident #259 required maximum assistance with transfers because he was unable to hold his balance. CNA #1 said Resident #259 was unable to get up by himself most of the time, but a few times he was able to get up without assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said he thought Resident #259 had sustained recent falls because he wanted and needed to move. He said the facility staff kept the door open to Resident #259's room as much as possible to keep an eye on him. Registered nurse (RN) #1 was interviewed on 4/3/25 at 2:31 p.m. RN #1 said she was unaware Resident #259 had sustained any recent falls. She said she was an agency nurse. She said she had not been informed Resident #259 was a fall risk. RN #1 said Resident #259 had dementia, but she never witnessed the resident having any hallucinations or behaviors. She said she was unaware of the fall interventions for Resident #259. The NHA and the director of nursing (DON) were interviewed together on 4/3/25 at 4:18 p.m. The DON said she was not aware of Resident #259 having any hallucinations or psychosis prior to or after the recent falls. She said she was unable to find documentation of non-pharmacological interventions that were put in place following the falls and prior to the ordering and administration of Seroquel, an anti-psychotic medication. She said she was not sure why Resident #259 was up early in the morning or late at night, but she would have guessed it was because of the progression of his disease. She said she was unable to find documentation that the facility had determined the root cause of the resident's restlessness of getting up without assistance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47350 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in accordance with professional standards in one of one medication storage rooms. Specifically, the facility failed to ensure Tubersol (tuberculin purified protein derivative), Hepatitis B vaccine, Prevnar (pneumococcal vaccine), Fluzone (influenza vaccine), Spikevax (COVID-19 vaccine) and Basaglar insulin pens were stored within the appropriate medication storage refrigerator temperature guidelines. Findings include: I. Professional reference According to The Centers for Disease Control and Prevention (CDC) (3/29/24) Vaccine Storage and Handling Toolkit, retrieved on 4/8/25 from https://www.cdc.gov/vaccines/hcp/downloads/storage-handling-toolkit.pdf, If the cold chain is not properly maintained, vaccine potency may be lost, resulting in an unusable vaccine supply. According to the Sanofi Pasteur (2020) package insert for Tuberculin Purified Protein Derivative (Mantoux): Tubersol Food and Drug Administration (FDA), retrieved on 4/8/25 from www.fda.gov/media/74866/download, Store at 35 to 46 degrees Fahrenheit (F). According to the Merck Vaccine (2024) Storage and Handling of Recombivax B (Hepatitis B) guidelines, retrieved on 4/8/25 from https://www.merckvaccines.com/recombivax-hb/storage-handling/#:~:text=Storage%20and%20Handling%20for%20RECOMBIVAX%20HB%C2%AE%20[Hepatitis, DO%20NOT%20FREEZE%20since%20freezing%20destroys%20potency, Store vaccine vials and syringes at 36 to 46 degrees Fahrenheit; storage above or below the recommended temperature may reduce potency. According to the Moderna (2025) Spikevax (Covid 19) vaccine storage and handling guidelines, retrieved on 4/8/25 from https://products.modernatx.com/spikevaxpro/dosing-and-administration, Store frozen between -50 degrees F to 5 degrees F. Storage after thawing, store refrigerated between 36 degrees F to 46 degrees F for up to 60 days prior to use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Pfizer (January 2025) Prevnar 20 Storage and Handling Guidelines, retrieved on 4/8/25 from https://prevnar20adult.pfizerpro.com/administration, Store refrigerated at 36 to 46 degrees F. According to the Sanofi Pasteur (July 2022) Fluzone Quadrivalent Influenza Vaccine Storage and Handling Guidelines, retrieved on 4/8/25 from https://www.fda.gov/media/119856/download, Store at 35 to 46 degrees F. According to Lilly (2024) Basaglar Insulin Pen Storage Guidelines, retrieved on 4/8/25 from https://insulins.lilly.com/basaglar, Before insulin use: When you get your unused pens, your insulin should be refrigerated at 36 degrees F to 46 degrees F. II. Facility policy and procedure The Medication Labeling and Storage policy and procedure, revised February 2023, was provided by the nursing home administrator (NHA) on 4/3/25 at 7:18 p.m. It read in pertinent part, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. III. Observations On 4/3/25 at 1:25 p.m. the unit medication storage refrigerator was observed with the director of nursing (DON), who was also the facility's infection preventionist (IP). The medication storage refrigerator temperature was at 50 degrees F. -The medication storage refrigerator was not within the safe refrigerated medication storage temperature range of 36 degrees F to 46 degrees F The following items were found inside the medication storage refrigerator: -A vial of Tubersol; -A hepatitis B vaccine vial; -A Prevnar 20 vaccine vial; -A Fluzone influenza vaccine syringe; -A Spikevax vaccine syringe; and, -A Basaglar insulin pen. IV. Staff interview (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 4/3/25 at 1:30 p.m. The DON said the medication storage refrigerator should be between 36 degrees F and 46 degrees F. She said the night shift nurses should check the refrigerator but there was no documentation that this was done. She said the facility did not have a refrigerator temperature log. She said she did not know how long the refrigerator had been above the safe storage temperature range. She said she would have the maintenance director (MTD) look at the refrigerator. The DON was interviewed a second time on 4/3/25 at 4:20 p.m. The DON said the MTD was going to order a new medication storage refrigerator, since the current refrigerator did not seem to be holding the correct temperature.

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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 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** 51915 Based on record review and interviews, the facility failed to assist residents to obtain routine or emergency dental services, as needed, for one (#12) of one resident reviewed for ancillary services out of 30 sample residents. Specifically, the facility failed to ensure a dental referral was followed upon timely for Resident #12. Findings include: I. Facility policy and procedure The Resident Dental Services policy and procedure, dated December 2016, was provided by the nursing home administrator (NHA) on 4/3/25 at 4:30 p.m. It revealed in pertinent part, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentists, or referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation, arrangements, and for reimbursement of dental services under the state plan, if eligible. Direct care staff will assist residents with denture care, including removing, cleaning, and storing dentures. If dentures are damaged or lost, residents will be referred for dental services within three days. If the referral is not made within three days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services and the reason for the delay. II. Resident #12 A. Resident status Resident #12, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, left hemiplegia (paralysis on one side of the body) following cerebral infarction, major depressive disorder and post-traumatic stress disorder. The 2/20/25 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. She required maximum assistance with transfers and bed mobility and moderate assistance for bathing, toileting, dressing and personal hygiene. B. Resident interview (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 was interviewed on 4/1/25 at 9:55 a.m. Resident #12 said she had had pain in her bottom jaw for a long time now. She said she saw the dentist at the facility quite a few months prior and was still waiting for another appointment. She said she had not received any communication from the facility on when her dental appointment would be. Resident #12 said she was having pain, but was still able to eat. C. Record review The 4/24/24 dental progress note revealed Resident #12 presented with soreness in the lower jaw. The 11/13/24 dental progress note revealed Resident#12 was seen for treatment due to soreness in the lower jaw and indicated the resident experienced tenderness to the lower ridge. The dentist documented a referral for the resident to have an alveoloplasty (a surgical procedure where the jawbone is reshaped and smoothed, particularly after tooth extraction, to prepare for dentures or dental implants) of her lower ridge (alveolar ridge located just below the bottom teeth). A review of Resident #12's electronic medical record (EMR) did not reveal documentation the facility had followed up on the dental referral from 11/13/24. III. Staff interviews The NHA was interviewed on 4/3/25 at 1:42 p.m. The NHA said the social services department was responsible for the coordination of all ancillary services, including dental care. She said the facility was currently in the process of hiring social services staff. The NHA said she was unable to find documentation that the dental referral had been made for Resident #12, based on the dentist's recommendation from November 2024. She said she would contact the dentist to determine where Resident #12 should be sent for the procedure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on three of three units. Specifically, the facility failed to: -Ensure hand hygiene was performed during wound care; -Ensure clean technique was followed during wound care; -Ensure residents' rooms were cleaned in a sanitary manner; -Ensure laundry was sorted in a sanitary manner; -Ensure laundry was washed in a different cycle for residents in isolation; and, -Ensure residents' personal items were labeled and stored in a sanitary manner. Findings include: I. Facility policy and procedure The Infection Prevention and Control Program (IPCP) and Plan, revised October 2018, was provided by the nursing home administrator (NHA) on 3/31/25 at 1:10 p.m. It revealed in pertinent part, An IPCP is established and maintained to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards. II. Failed to ensure hand hygiene and clean technique was followed during wound care A. Professional references According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene for Healthcare Workers, updated 2/27/24, retrieved on 4/8/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings, always clean your hands after removing gloves, remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil your hands. B. Observations On 4/2/25 at 1:15 p.m. the director of nursing (DON), who was also the facility's infection preventionist (IP), and the wound care physician entered Resident #40's room to perform wound care for the resident on his left foot. The following observations were made: The DON performed hand hygiene and donned a gown and a pair gloves upon entering the resident's room. The DON brought in wound dressing supplies and placed them on the resident's bedside table. The DON then removed the heel boot on Resident #40's left foot. The DON removed the old dressing on Resident #40's left lateral foot. The DON placed the old dressing on the bed. The DON placed a disposable underpad on the bed under the resident's left foot, on top of the old dressing. The DON then used a clean gauze and an individual saline solution vial to wipe the wound. The DON disposed of the gauze and saline solution. The DON opened the resident's clean dressing from the bedside table and applied the dressing. -Throughout the wound care process, the DON failed to establish and maintain a clean field for the resident's clean wound supplies. -Additionally, the DON failed to perform hand hygiene and change gloves after touching the old soiled wound dressing and before touching the clean wound supplies and applying a new dressing to the resident's left foot wound. On 4/2/25 at 1:30 p.m. the DON and the wound care physician entered Resident #33's room to perform wound care for the resident. The following observations were made: The DON removed clean dressing supplies from the wound care cart. The DON donned gloves and a gown. The DON placed the clean wound care supplies on Resident 33's wheelchair at the end of the bed. The DON removed the resident's left heel boot. The DON picked up the betadine pain stick and painted the resident's left heel with betadine. The DON then obtained saline and clean gauze and removed the soiled dressing from the resident's sacral wound. She cleaned the sacral wound and applied a clean dressing. The DON then removed her gown and gloves and disposed of the soiled dressing supplies in the trash. -Throughout the wound care process, the DON failed to establish and maintain a clean field for the resident's clean wound supplies. -The DON failed to perform hand hygiene before donning gloves and a gown. -Additionally, the DON failed to perform hand hygiene and change gloves after cleaning the resident's left heel wound and before proceeding to the resident's sacral wound. -The DON failed to change her gloves and perform hand hygiene after removing Resident #33's soiled sacral wound dressing and before cleaning the wound and applying a new dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 1:45 p.m. the DON and the wound care physician entered Resident #20's room to perform wound care for the resident. The following observations were made: The DON removed clean dressing supplies from the wound cart. The DON donned gloves and a gown. The DON pulled back the resident's incontinence briefs and removed the old soiled dressing from the resident's sacral wound. The DON opened clean wound care supplies and applied silver alginate (an antibacterial wound treatment) and a border dressing. The DON removed her gown and gloves and disposed of everything in the trash. -Throughout the wound care process, the DON failed to establish and maintain a clean field for the resident's clean wound supplies. -The DON failed to perform hand hygiene before donning gloves and a gown. -Additionally, the DON failed to perform hand hygiene and change gloves after removing the resident's old wound dressing and before touching the resident's clean dressing supplies. C. Staff interviews The DON was interviewed on 4/2/25 at 2:52 p.m. The DON said before performing wound care, a clean field should be established. She said a bedside table or designated surface should be wiped down with the Super Sani Cloth germicidal and disinfectant wipes. She said this should be done before placing any clean dressing supplies on top of the surface. She said hand hygiene should be done before putting on gloves and a gown. She said hand hygiene should be performed and gloves should be changed after touching a dirty area and before touching clean wound supplies. III. Failed to ensure resident's rooms were cleaned in a sanitary manner A. Professional reference The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), was retrieved on 4/8/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Clean resident areas before cleaning resident toilets. Include identified high touch surfaces and items in checklists and other job aids to facilitate completing cleaning procedures. Proceed in a systematic manner to avoid missing areas. In a multi-bed area, clean each resident zone in the same manner. For higher risk areas, change cleaning cloths between each resident zone (use a new cleaning cloth for each resident bed). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Facility policy and procedure The Daily Room Cleaning Procedures policy and procedure, undated, was provided by the NHA on 4/3/25 at 7:18 p.m. It revealed in pertinent part, Always start with cleaning the resident's restroom. Disinfect toilet bowls and urinals. C. Manufacturer's recommendations The Diffense Cleaner and Disinfectant manufacturer guidelines, 2025, was retrieved on 4/8/25 from https://www.sfreedman.com/products/1024-spartan-rtu-diffense-clnr-quart/525039070/?srsltid=AfmBOoo7j5wqpwdbMMjm1Fj0oNYH2ChUBkqNjJgQ6mERSEMaPhUfyA2Z. It read in pertinent part, Effective against a comprehensive range of harmful bacteria and viruses and less than one minute disinfection. D. Observations On 4/3/25 at 8:53 a.m. housekeeper (HK) #1 was observed cleaning a shared room [ROOM NUMBER]. HK #1 put on gloves and obtained a disinfectant-saturated rag from the housekeeping cart and wiped the bedside table on the A side of the room. She then wiped down the window sill and the bedside table on the B side of the room. After wiping both residents' bedside tables and the windowsill with the same rag, she disposed of the rag. She then mopped the entire room, starting from the far side of room (the B side), mopping under both beds and mopped her way to the door. After finishing the mopping, HK #1 disposed of the mop head and swept up the debris. -HK #1 failed to clean the resident's area on the B side of the room separately from the resident's area on the A side of the room. -HK #1 failed to change gloves, perform hand hygiene or change rags before proceeding from the A side to the B side of the room. -HK #1 failed to change mop heads after mopping the B side of the room before mopping the A side of the room. -HK #1 failed to clean the high touch areas in the room, including light switches and door knobs. E. Staff interview (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance director (MTD), who was also the housekeeping supervisor, was interviewed on 4/3/25 at 9:20 a.m. The MTD said HK #1 should not be interviewed because she was new to the position and because of the language barrier. He said the cleaner/disinfectant the facility used had a one-minute disinfection time. He said residents' rooms were cleaned starting from high areas to low areas. He said high touch areas, such as light switches and door handles should be included when the rooms were cleaned. IV. Failed to ensure laundry was sorted in a sanitary manner and laundry was washed in a different cycle for residents on isolation precautions A. Professional reference According to the CDC's Appendix D-Linen and Laundry Management (3/19/24), retrieved on 4/9/25 at 2:04 p.m. from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html, Use hot water 70 degrees Celsius (C) to 80 degrees C for 10 minutes or 158 degrees Fahrenheit (F) to 176 degrees F and an approved laundry detergent. Use disinfectant on a case by case basis, depending on the origin of the soiled linen (for example, linens from an area on contact precautions). B. Facility policy and procedure The Departmental (Environmental Service) Laundry and Linen policy and procedure, revised January 2014, was provided by the NHA on 4/3/25 at 7:50. It read in pertinent part, Consider all soiled linen to be potentially infectious and handle with standard precautions. Laundry for high temperature processing, wash linen in water that is at least 160 degrees F for a minimum of 25 minutes. C. Observations and staff interview On 4/3/25 at 9:42 a.m. the laundry area was observed with the MTD, the NHA and the laundry aide (LA). The laundry area was entered through the clean sorting room. The MTD explained the laundry process. The door opening where the laundry carts were sent for dirty laundry had a door leading to the soiled laundry sorting room. Upon entering the sorting room, the LA said she put on a gown first prior to sorting the laundry. Multiple cloth long sleeve gowns were observed hanging on hooks behind the laundry sorting room door. The reusable gowns were overlaying each other and touching other gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LA said she washed the reusable protective gowns maybe once a week, but not after each use. The LA said she did not know of any potential infection control issues with that practice. The MTD said not washing the gowns after each use created the potential for cross contamination. The MTD said he would get the laundry staff more gowns to use and dispose of after each time they sorted the soiled laundry items. The LA said she would put on gloves and use a tie to close the sleeves of the gown at her wrist because the gown sleeves were too long. The LA pointed to three black hair ties hanging on the wall with a thumb tack. The LA said she used the hair ties all of the time and did not clean them after use. The NHA said the hair ties were not cleanable and should not be used. The MTD said it was possible for the debris from the soiled clothing and linen to be transferred to the hair ties. V. Failed to ensure residents' personal items were labeled and stored in a sanitary manner A. Observations On 3/31/25 the following observations were made: -At 1:45 p.m. room [ROOM NUMBER], a shared room, had on the vanity below the mirror two unlabeled toothbrushes, one unlabeled container of Listerine and one unlabeled deodorant; and, -At 1:52 p.m. room [ROOM NUMBER], a shared room, had on the vanity below the mirror two unlabeled toothbrushes. On 4/1/25 the following observations were made: -At 9:21 a.m. room [ROOM NUMBER], a shared room, had on the vanity below the mirror two unlabeled toothbrushes; -At 11:00 a.m. room [ROOM NUMBER], a shared room, had on the vanity one unlabeled toothbrush; -At 11:02 a.m. room [ROOM NUMBER], a shared room, had two unlabeled toothbrushes on the vanity; -At 11:03 a.m. room [ROOM NUMBER], a shared room, had a cup with one unlabeled toothbrush sitting on the vanity; and, -At 11:05 a.m. room [ROOM NUMBER], a shared room, had a cup which contained two unlabeled toothbrushes. B. Staff interview (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and the NHA were interviewed together on 4/3/25 at 4:15 p.m. The DON said she was responsible for ensuring that residents' toothbrushes were labeled and stored in a sanitary manner. She said in the past, the facility had used special covers for the toothbrushes and had labeled them. She said over time, the special toothbrush covers had been thrown away. She said she would get new covers for the toothbrushes and ensure they were labeled for each specific resident.

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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** 47350 Based on record review and interviews, the facility failed to implement policies and procedures related to influenza and pneumococcal vaccines for two (#26 and #43) of five residents reviewed for immunizations out of 30 sample residents. Specifically, the facility failed to: -Document the influenza vaccine was offered annually for Resident #26 and #43; -Document the pneumonia vaccine was reoffered for Resident #26; and, -Administer the pneumococcal vaccination after consent was provided for Resident #43. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC), updated 2025, Recommended Immunization Schedule for Adults Aged [AGE] years or Older, retrieved on 4/10/25 from https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf, Pneumococcal vaccination-Routine vaccination-Age [AGE] years or older who have not previously received a dose of PCV13 (pneumococcal conjugate vaccine), PCV15, PC20, OR PCV21 or whose previous vaccination history is unknown: one dose PCV15 or PCV20 or one dose PCV21. If PCV15 is used, administer one dose PPSV23 at least one year after the PCV15 dose (may use a minimum interval of eight weeks for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak). Previously received only PCV7: follow the recommendation above. Previously received only PCV13: one dose PCV20 or one dose PCV21 at least one year after the last PCV13 dose. Previously received only PPSV23: one dose PCV15 or one dose PCV20 or one dose PCV21, at least one year after the last PPSV23 dose. If PCV15 is used, no additional PPSV23 doses are recommended. Previously received both PCV13 and PPSV23 but no PPSV23 was received at age [AGE] years or older; one dose PCV20 or one dose PCV21 at least five years after the last pneumococcal vaccine dose. Previously received both PCV13 and PPSV23, and PPSV23 was received at age [AGE] years or older: Based on shared clinical decision making, one dose of PCV20 or one dose of PCV21 at least five years after the last pneumococcal vaccine dose. II. Facility policy and procedure (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Seasonal Influenza, Prevention and Control policy and procedure, revised March 2022, was provided by the nursing home administrator (NHA) on 4/3/25 at 7:18 p.m. It read in pertinent part, All residents and staff are offered the vaccine prior to the onset of the influenza season. All residents and staff are encouraged to receive the vaccine unless there is a medical contraindication. The Vaccination of Resident policy and procedure, revised October 2019, was provided by the NHA on 4/3/25 at 7:18 p.m. It read in pertinent part, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. All new residents shall be assessed for current vaccination status upon admission. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: site of administration, date of administration, lot number of the vaccine, expiration date and name of person administering the vaccine. III. Resident #26 A. Resident status Resident #26, age 75, was admitted on [DATE] readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), the diagnoses included pneumonia, type 2 diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD) and vascular dementia. The 1/15/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. She required substantial/maximal assistance with toileting, personal hygiene. She required partial/moderate assistance with bed mobility and was independent with eating. The assessment indicated the resident had been offered and she had declined the influenza vaccine for the years' influenza season. The assessment indicated the resident had been offered and she had declined the pneumonia vaccine. B. Record review A review of the Resident #26's electronic medical record (EMR) on 4/3/25 revealed a consent form for influenza and pneumonia vaccine. The form indicated the resident declined the influenza and pneumonia vaccine on 4/15/22. -A review of the EMR on 4/3/25 failed to reveal documentation that the influenza vaccine or the pneumonia vaccine was reoffered annually. IV. Resident #43 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #43, age 74, was admitted on [DATE]. According to the April 2025 CPO, the diagnoses included COPD and stage 4 severe chronic kidney disease (CKD), The 1/8/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. He was independent with eating, toileting, personal hygiene, bed mobility and transfers. The assessment indicated the resident had been offered and he had declined the influenza vaccine for the years' influenza season. The assessment indicated the resident had been offered and he had declined the pneumonia vaccine. -However, review of Resident #43's consent form revealed the resident indicated he wanted to receive the pneumonia vaccine on 2/17/23 (see record review below). B. Record review A review of Resident #43's EMR on 4/3/25 revealed a consent form for the influenza and the pneumonia vaccine that documented the resident declined the influenza vaccine and wished to receive the pneumonia vaccine on 2/17/23. -A review of the EMR on 4/3/25 failed to reveal documentation of the influenza vaccine being reoffered annually. -A review of the EMR on 4/3/25 failed to reveal documentation that the pneumonia vaccine was administered after the resident signed the consent form for permission to receive the vaccine. V. Staff interviews The director of nursing (DON) was interviewed on 4/3/25 at 2:26 p.m. The DON said that many of the residents declined immunizations because they did not trust the government. She said the consents for immunizations were completed when a resident was admitted to the facility. She said the form was then uploaded into the residents' EMR. She said the information of vaccines received and refused were documented under the immunization tab in the resident's medical record. She said they offered the vaccines every year and the residents' acknowledgment of education of risk versus benefit was documented on the consent.