STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065286	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Ridge Post Acute	2425 Teller Ave Grand Junction, CO 81501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40467 Based on record review and interviews, the facility failed to act promptly upon the grievances concerning issues of resident care and life in the facility that were important to the residents. Specifically, the facility failed to timely create effective interventions and maintain a systematic approach to ongoing resident grievances of call light response times addressed in resident council. Findings include: I. Facility policy and procedure The Resident Council policy, revised April 2017, was provided by the nursing home administrator (NHA) on 6/12/24 at 11:23 a.m. The policy read in pertinent part, The purpose of the resident council is to provide a forum for: -Residents, families and resident representatives to have input in the operation of the facility; -Discussion of concerns and suggestions for improvement; -Consensus building and communication between residents and facility staff; and, disseminating information and gathering feedback from interested residents. A resident council response form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the items of concern. The quality assurance and performance improvement (QAPI) committee will review information and feedback from the resident council as part of their quality review. Issues documenting on the resident council response forms may be referred to the copy committee if applicable. The Grievance/Complaints, recording and investigating policy, revised April 2017 was provided by the NHA on 6/12/24 at 11:23 a.m. The policy read in pertinent part, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievances. II. Resident group interview (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Six residents (#5, #7, #20, #24, 26 and #34), who were identified as interviewable by the facility and assessment, were interviewed on 6/6/24 at 10:00 a.m. During the group interview the following comments were made regarding call light response time: -Had to wait a long time for staff to respond to a call light to have assistance off the toilet. -When staff respond to the call light they turn it off and come back later or do not come back. -The nurses would turn off the call light and say they would tell someone else but no one returns. -Feel angry when the staff does not come back to help. -Staff said they have to find a partner to help with the two person transfer. The CNA could not always able to find a partner so they do a two person transfer by themselves. -Had to wait anywhere between five minutes and two hours for call lights. -There was too much staff turnover which contributed to the long call lights. The slow call lights were sometimes because staff were talking to each other and not responding to the residents. The residents said they had told the staff their call light concerns. The following comments were made: -When a call concern was brought up, staff said they would look into it or take care of it. -Grievances were filed but nothing was done about the call lights. -It does not do any good to file a grievance. -When trying to talk to the administration they say they have the amount of staff they need or are not able to get all the staff they need. III. Additional resident interviews Resident #7 was interviewed on 6/05/24 10:11 a.m. Resident #7 said she has had to wait over an hour for her call lights to be answered after she initiated it. She said she and her roomate sometimes had to work together to push both call lights to get response from staff. Resident #54 was interviewed on 6/05/24 10:11 a.m. Resident #54 said she had waited over an hour for call light to be answered. Resident #16 was interviewed on 6/5/24 at 2:19 p.m. Resident #16 said nursing staff needed help. He was a two person assistance for turns in bed or transfers with the hoyer lift. He said sometimes he had to wait a really long time for help. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 was interviewed on 6/5/24 at 3:11 p.m. Resident #28 said when the certified nurse aides (CNA) answered her call light, they would turn it off and say they would come back later. Resident #27 was interviewed on 6/5/24 at 11:21 a.m. Resident #27 said she has had to wait over an hour for staff to respond to her call light. Resident #25 was interviewed on 6/5/24 at 10:38 a.m. Resident #25 said he has had to wait more than an hour for his call light to be answered. Resident #47 was interviewed on 6/5/24 at 12:48 p.m. Resident #47 said lately he had waited 30 minutes for a call light response. Resident #40 was interviewed on 6/5/24 at 5:26 p.m. Resident #40 said the facility was short staffed at night. She said the facility had one CNA in her hall and there were residents who needed multiple staff to transfer them while other residents had to wait. She said the longest wait she has had was 45 minutes. She said she had spoken to the director of nursing (DON) and the night nurses about the concern but nothing had been done about it. IV. Resident council minutes The December 2023, January 2024, February 2024 and June 2024 resident council minutes were provided by the facility on 6/12/24. The March 2024, April 2024 and May 2024 resident council minutes were provided by the director of nursing (DON) on 6/5/24 at 10:48 a.m. via email. The review of the above resident council minutes identified residents indicated concerns with call light response. The concerns were not resolved according to the council minutes, resident interviews (see above interviews) or resident call light response time logs. The December 2023 resident council minutes read call light times were still an issue. According to the minutes the residents said the facility needed more CNAs for day and night shifts. The January 2024 resident council minutes documented under the old business section that the call lights were not answered in a timely manner. The action to address the concern was to follow-up on call light audits and cameras. The status for the concern was unresolved. According to the January 2024 minutes the residents still felt call light timeliness was still a concern. The minutes read a new call light system was in process to be installed. The system would record how long it took to answer a call light. Meanwhile, the facility could look back at cameras to calculate timing of call lights. The February 2024 resident council minutes identified the residents said the call lights were still taking too long to be answered. The ongoing call light concern remained unresolved and noted on the minutes and staff was still working on the concern. There were no new actions identified in the February 2024 resident council minutes to resolve the concern. The March 2024 resident council minutes read the call light concern was unresolved and the residents felt call light response times were still too long per residents. According to the minutes, the facility was still working on the issue but saw an improvement. According to the minutes, the DON educated nursing and touched on the topic in staff meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The grievance form did not identify when the education with the night staff was completed or if it was completed. The grievance form did not identify a follow up with a resident was conducted to ensure action taken resolved the call light concern 10 days after the action plan was implemented. A 1/8/24 grievance form from Resident #7 who attended the 1/8/24 resident council, documented she felt her call light took 15 to 20 minutes to answer and then the staff assisted her roommate but not checked on her needs. The resident said she had to push the call light a second time and wait again. According to the grievance, the resident said one day it took four hours to answer her call light and she missed two smoke breaks. The findings read the residents' usual wake time had changed from 10:00 a.m. to 7:00 a.m. The resident wanted to get up at 7:00 a.m. The resolution read staff were educated to ask both residents in the room if they needed assistance. Resident #7 agreed to speak up when the CNAs were in her room to let them know she needed assistance. The grievance form read the grievance was resolved on 1/10/24 and the resident refused to sign. -The grievance form did not identify when the staff were educated. The grievance form did not identify a follow up with a resident was conducted to ensure action taken resolved the call light concern 10 days after the action plan was implemented. -No grievance forms were generated after the February 2024 resident council meeting. A 3/11/24 grievance form from Resident #44 who attended the 3/11/24 resident council, documented the resident felt she waited a considerable amount of time for her call light to be answered. According to the findings a call light audit on the resident's call light time was conducted on 3/11/24 and 3/12/24 with four call light observations. The response time ranged between less than one minute and under six minutes. The resolution read education was provided to the floor staff on answering call lights in a timely manner. The resolution was signed by the DON and the residents on 3/18/24. The date resolved was not marked. Attached to the 3/11/24 grievance form was an education with six staff. The education read call light should not be longer than 10 minutes. It was the responsibility of the employee to answer the call lights promptly and failure to do so would result in disciplinary action. The education read call lights were to be answered as soon as possible for the safety and well being of the residents. -The review of the grievance forms did not identify new grievance forms were generated for call lights after the resident council continued to address concerns with call lights in April 2024, May 2024 and June 2024. VI. Call light audits The call light audits were provided by the NHA on 6/12/24 at 11:23 p.m. The call lights audits were conducted in June 2023, September 2023, and November 2023. -The review of call light audits did not identify call light audits were conducted in January 2024 or the following month as indicated in the January 2024 resident council minutes. VII. Staff education The all staff education agendas were provided by the NHA on 6/12/24 at 10:47 a.m. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2024 staff education read in pertinent part, Residents continue to stay there light is on for extended periods of time. all staff may answer a call light. It is not just the floor CNAs and nurses responsible for answering call lights. Our new call system is currently being installed. This will allow us to know how long a call light has been on. If you answer the call light and need to find a second person to assist you, please leave the call light on while you are looking for hebe pulled in many directions. -The February 2024 all staff meeting agenda did not identify call light response times were addressed in the meeting. -The March 2024 all staff meeting agenda did not identify call light response times were addressed in the meeting. -The April 2024 all staff meeting did not identify call light response times were addressed in the meeting. -The review of the provided staff education identified the resident council call light response concern was only addressed during the January 2024 all staff meeting. VIII. Call light logs The call light logs between 3/1/24 and 6/1/24 were reviewed. The call light log identified numerous call lights with high call wait times throughout the facility and throughout the day and night. The following sample call light times were reviewed for 3/1/24, 4/1/24, 5/1/24, and 6/1/24. The following call light response times were logged on 3/1/24 at: -3:38 a.m. for 16 minutes; -4:55 a.m. for 22 minutes; -6:35 a.m. for 35 minutes; -6:58 a.m. for 27 minutes; -7:31 a.m. for 22 minutes; -8:22 a.m. for 21 minutes; -8:42 a.m. for 23 minutes; -10:56 a.m. for 53 minutes; -11:45 a.m. for 29 minutes; -12:44 p.m. for 29 minutes; -1:22 p.m for 23 minutes; (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5:19 p.m. for 51 minutes; -5:36 p.m. for 37 minutes; -6:07 p.m. for 38 minutes; -6:31 p.m. for 26 minutes; -6:50 p.m. for 43 minutes; -7:09 p.m. for 20 minutes; -7:28 p.m. for 22 minutes; -7:57 p.m. for 23 minutes; and, -8:33 p.m. for 46 minutes. The following call light response times were logged on 4/1/24 at: -1:00 a.m. for 23 minutes; -5:45 a.m. for 45 minutes; -6:25 a.m. for 20 minutes; -8:41 a.m. for 28 minutes; -9:06 a.m. for 20 minutes; -9:18 a.m. for 43 minutes; -9:52 a.m. for 37 minutes; -10:41 a.m. for 28 minutes; -12:51 p.m. for 22 minutes; -1:17 p.m. for 25 minutes; -2:46 p.m. for 28 minutes; -3:19 p.m. for 47 minutes; -3:57 p.m. for 32 minutes; -7:30 p.m. for 46 minutes; and, (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11:01 p.m. for 26 minutes. The following call light response times were logged on 5/1/24 at: -12:07 a.m. for 21 minutes; -7:04 a.m. for 24 minutes; -7:20 a.m. for 20 minutes; -7:29 a.m. for 27 minutes; -9:24 a.m. for 31 minutes; -9:44 a.m. for 42 minutes; -10:00 a.m. for 24 minutes; -12:35 p.m. for 3 hours and 58 minutes; -12:40 p.m. for 21 minutes; -12:53 p.m. for 33 minutes; -1:05 p.m. for 44 minutes; -2:05 p.m. for 25 minutes; -2:30 p.m. for 23 minutes; -2:59 p.m. for 21 minutes; -6:00 p.m. for 44 minutes; -6:17 p.m. for 24 minutes; -6:18 p.m. for 34 minutes; -6:21 p.m. for 49 minutes; -6:57 p.m. for 26 minutes; -9:14 p.m. for 36 minutes; -9:17 p.m. for 21 minutes; and, -11:24 p.m. for 21 minutes. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following call light response times were logged on 6/1/24 at: -12:08 a.m. for 24 minutes; -12:24 a.m. for 22 minutes; -12:34 a.m. for 24 minutes; -1:20 a.m. for 47 minutes; -3:01 a.m. for 33 minutes; -6:08 a.m. for 22 minutes; -9:26 a.m. for 23 minutes; -11:48 a.m. for 27 minutes; -1:59 p.m. for 29 minutes; -3:07 p.m. for 21 minutes; -3:27 p.m. for 40 minutes; -6:59 p.m. for 21 minutes; -7:48 p.m. for 25 minutes; and, -8:42 p.m. for 28 minutes. IX. Staff interviews The social service director (SSD) was interviewed on 6/11/24 at 1:17 p.m. The SSD said when a concern was brought up in the resident council meeting, she would start a grievance form and delegate the concerns to the appropriate department. She said a response needed to be completed within seven days of the concern. She said the identified concern would be discussed during the following resident council meeting. She said if the residents did not feel the concern was resolved, the concern was considered ongoing until it was resolved. The SSD said the action plan to improve call lights was call light audits and the call light system was upgraded. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activity director (AD) was interviewed on 6/12/24 at 9:39 a.m. The AD said after the resident council meeting, she and the SSD wrote up the grievances together. She said the SSD delegated the grievances. She said the concerns/grievances were reviewed in the next resident council meeting and the residents were asked if they felt the concern was resolved and the concern closed. The AD said the call light wait times had been an ongoing issue for the residents since December 2023. The AD said the NHA told the residents she was trying to figure out how to improve call light times. The AD said there had been some staff education but the residents still felt they had long call light waits. She said the residents said there was some improvement but call light concern had been an important issue for the residents and the residents felt it still was not resolved. The AD said the residents should be able to voice their opinions and feel they were heard and their concerns were followed up on. The NHA was interviewed on 6/12/24 at 9:56 a.m. The NHA said the former assistant director of nursing was responsible for documenting staff education but she was just having staff sign off an education without specifying what education was provided. She said the new call light system and reminding staff to answer call lights was reviewed in the all staff meeting in January 2024. The NHA said she did not have additional records to show additional education with call light response times were completed. The NHA said she was aware of one grievance filed by a resident regarding call lights when the resident was left on the toilet. The NHA said the facility also completed call light audits. The NHA said when a resident filed a grievance, they signed the grievance form and staff talked to them about the concern. The NHA said all grievances should be addressed on a grievance form. The regional operations manager (ROM) was interviewed on 6/12/24 at 11:05 a.m. The ROM said the call light times were reviewed daily in the morning meeting. He said the average wait time was around eight minutes with some occasional outliers. She said there had not been too many concerns other than one resident expressed a concern in March 2024 about staff turning off call lights. The DON was interviewed on 6/12/24 at 12:13 p.m. The DON said she educated some of the staff a couple of months ago that call lights should be answered in 10 minutes or less after a resident complained about long call lights (refer to March 2024 grievance above). She said in January 2024, at the all staff meeting, the staff were reminded it was everyone's responsibility to answer the call lights. The DON said a lot of the call lights could be addressed by non-clinical staff. The DON said prompt response to call lights could reduce falls to prevent the residents from attempting to do things by themself. She said in the monthly resident council meeting usually one resident brought up the call light concern and then the other residents would agree. The DON said she reviewed the call light log and confirmed times of 45 minutes occurred most frequently between 7:00 p.m. and 9:00 p.m. The DON said call lights were not a concern until December 2023. She said there had been a resident census increase but it fluctuated. She said she was trying to get more staff to work the evening hours. She said at night there were three CNAs but she wanted to try to have four CNAs. She said there had been staff turn over recently. She said two CNAs were hired but then quit. She said one of the CNAs might return. She said the facility recently started advertising the positions and agency staff would help provide coverage starting on 6/17/24 to help during the night peak times. The DON said the root cause of the call light concerns was there were three CNAs scheduled at night and the facility needed four CNA's. The DON said she started scheduling four CNAs as of 6/1/24 to provide additional help with night time activities of daily living (ADL) care. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 48412 Based on record review and interviews, the facility failed to ensure that personal funds accounts were managed adequately for one (#19) of five residents out of 45 sample residents. Specifically, the facility failed to have personal funds withdrawal sheets signed to ensure the Resident #19' s permission was obtained to withdraw funds from his personal needs account. Findings include: I. Personal funds withdrawal The Personal Funds Withdrawal sheet was reviewed for Resident #19 on 6/10/24. The resident was found to have three withdrawals from his account with no signed authorization. The withdrawals were as follows: -On 5/7/24 a withdrawal was made for $94.00; -On 4/11/24 a withdrawal was made for $105.00; and, -On 3/4/24 a withdrawal was made for $110.00. -The facility failed to provide receipts or signed authorization from the resident for the withdrawals. II. Staff interviews The business office manager (BOM) was interviewed on 6/11/24 at 11:45 a.m. The BOM said Resident #19' s legal representative requested the resident' s funds from the resident' s personal needs account each month to pay for Resident #19' s bills. She said she had another representative who did the same thing but provided a copy of the receipts for the bill. She said she never thought of asking Resident #19' s legal representative to provide receipts. The BOM said she had no way to prove the money was used for the resident' s bills or not. The BOM said she was unaware the resident was supposed to sign a personal funds withdrawal for his legal representative to spend his personal funds. The BOM said she was auditing all of the resident' s accounts to update the consent forms and ensure the residents signed for the use of personal funds.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to inform one (#216) of three residents reviewed for beneficiary notices out of 45 sample residents of changes in their services covered by Medicare in a timely manner. Specifically, the facility failed to provide a Notice of Medicare Provider Non-Coverage (NOMNC) to Resident #216 two days prior to discharge of Medicare Part A funded services. Findings include: I. Facility policy and procedure The NOMNC procedure was provided by the nursing home administrator (NHA) on [DATE] at 10:15 a.m. It read in pertinent part, A Medicare provider must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries or enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility and hospice services. The NOMNC must be delivered at least two calendar days before Medicare-covered services end. II. Record review A. Resident #216 The electronic medical record (EMR) revealed Resident #216 was discharged from Medicare Part A funded therapy services on [DATE]. The resident was discharged to her home. The NOMNC was provided by the regional operations manager (ROM) on [DATE] at 10:15 a.m. The notice read the resident's last covered day of Medicare Part A services would be [DATE]. The NOMNC notice was signed by Resident #216 on [DATE], the same day her Medicare Part A benefits ended. -Resident #216 was not given timely information about the termination of Medicare Part A services (within the required two calendar days notification timeframe), in order to give the resident the opportunity to appeal the decision if desired. III. Staff interviews The admission/discharge coordinator (ADC) was interviewed on [DATE] at 11:39 a.m. The ADC said the NOMNC was a notification of the discontinuation of Medicare part A l services. She said she provided NOMNCs to the residents 72 hours before residents'benefits ended. The ADC said there was not a set timeframe when she had to provide the NOMNC. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADC said she sent the NOMNC to Resident #216's medical durable power of attorney (MDPOA) 72 hours before the resident's benefits were going to expire. The ADC said she sent the NOMNC through the facility's electronic system and the system was unable to provide a confirmation. She said Resident #216's MDPOA lived out of the state and was unable to open the NOMNC to sign it. The ADC said Resident #216's MDPOA called and asked the ADC to have the resident sign the NOMNC and the resident signed it on [DATE]. The ADC said she signed verbal consents on the NOMNC if the MDPOA did not ask for the resident to sign it. The ADC was interviewed again on [DATE] at 8:57 a.m. The ADC said she was unaware there was a requirement for the NOMNC to be provided at least two calendar days before benefits expired. The ADC said she was able to send NOMNCs through the facility's electronic system and she never received a confirmation that it was sent. She said she completed a lot of NOMNCs and there was no way for her to track the forms being sent before the benefits expired.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to investigate an allegation of abuse for one (#17) of three residents reviewed for abuse out of 45 sample residents. Specifically, the facility failed to investigate an incident where Resident #17 reported a staff member threatened him. Findings include: I. Facility policy The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 6/6/24 at 2:40 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The program consists of a facility-wide commitment and resource allocation to support the following objectives: -Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone; -Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents; -Establish and maintain a culture of compassion and caring for all residents; -Provide staff orientation and training or orientation programs that include such as abuse prevention and identification and reporting of abuse; -Implement measures to address factors that may lead to abusive situations; -Identify and investigate all possible incidents of abuse, neglect, mistreatment or misappropriation of resident property; -Investigate and report any allegations within timeframes required by federal requirements; and, -Protect residents from any further harm during investigations. The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy, revised September 2022, was provided by the NHA on 6/6/24 at 2:40 p.m. It read in pertinent part, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, theft or misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Upon receiving any allegations, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. All allegations are thoroughly investigated. The administrator initiates investigations. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. All relevant professional and licensing boards are notified when an employee is found to have committed abuse; If the investigation reveals that the allegation(s) of abuse are founded, the employee is terminated; Any allegations of abuse are filed in the accused employee's personnel record; If the investigation reveals that the allegation(s) of abuse are unfounded, the employee may be reinstated to their former position with back pay; Records concerning allegations that are determined to be unfounded are destroyed or archived per human resources policy; and, Corrective actions may include a full review of the incident by the quality assurance performance improvement (QAPI) committee. II. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included paraplegia (paralysis of the lower body), depressive episodes, muscle weakness and the need for assistance with personal care. The 4/16/24 minimum data set (MDS) assessment documented Resident #17 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. III. Resident interview Resident #17 was interviewed on 6/6/24 at 9:14 a.m. Resident #17 said he had an incident with a staff member and she raised her voice and yelled at him over a disagreement. Resident #17 said he did not want the situation to escalate because he was afraid of retaliation. He said he filed a grievance about the staff member being disrespectful. Resident #17 said the NHA told him the staff member was no longer assigned to his care. Resident #17 said he asked not to get in trouble repeatedly and said he was afraid of retaliation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Record review A copy of Resident #17's grievance form regarding the staff member was provided by the social services director (SSD) on 6/11/24 at 10:20 a.m. The grievance form documented the following: On 5/1/24 Resident #17 filed a grievance with the NHA. Resident #17 said that on 4/24/24 the admission and discharge coordinator (ADC) entered the resident's room to discuss a billing issue. Resident #17 said he felt threatened by the conversation. He said the ADC pointed outside and told him he would be on the street if the billing matter was not taken care of. The investigation findings documented the NHA had spoken to the ADC to let her know that Resident #17 no longer wanted to discuss personal matters with her. The intervention was documented as Resident #17 no longer wanted the ADC to handle his personal matters and he was fine with the rest of the administrative staff. V. Staff interviews The NHA was interviewed on 6/12/24 at 9:01 a.m. The NHA said she did not investigate the incident as abuse because she felt it was not an abuse situation. She said Resident #17 changed his story multiple times and then asked for it to be dropped because he did not want to cause any problems. The NHA said threats were considered abuse and she should have investigated it. She said the ADC was suspended on 6/12/24 (during the survey) and an investigation was started.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48412 Based on record review and interviews, the facility failed to coordinate assessment with the preadmission screening resident review (PASRR) program for five (#26, #36, #4, #18 and #22) of eight residents reviewed for PASRR out of 45 sample residents. Specifically, the facility failed to coordinate a PASRR Level II evaluation for Resident #26, #36, #4, #18 and #22. Findings include: I. Resident #26 A. Resident status Resident #26, age 71, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included generalized anxiety disorder and bipolar disorder (mental illness that causes shifts in a person's behaviors). The 2/26/24 minimum data set (MDS) assessment documented Resident #26 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #26 experienced feeling down, depressed or hopeless for several days during the review period. B. Record review Resident #26 had a PASRR Level I identification screen approved on 5/31/23 that documented a PASRR Level II was needed. -A review of Resident #26's electronic medical record (EMR) did not reveal documentation that a Level II PASRR had been completed. II. Resident #36 A. Resident status Resident #36, age 84, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included anxiety disorder and recurrent major depressive disorder. The 5/21/24 MDS assessment documented Resident #36 had a severe cognitive impairment with a BIMS score of four out of 15. Resident #36 had difficulty concentrating on things nearly every day. Resident #36 experienced feeling down, depressed or hopeless for more than half of the days during the review period. B. Record review (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 had a PASRR Level I identification screen approved on 5/9/23 that documented a PASRR Level II was needed. -A review of Resident #36's EMR did not reveal documentation that a Level II PASRR had been completed. III. Resident #4 A. Resident status Resident #4, age 86, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included major depressive disorder, unspecified intellectual disabilities and adult failure to thrive. The 4/30/24 MDS assessment documented Resident #4 had moderate cognitive impairments with a BIMS score of 12 out of 15. Resident #4 experienced trouble falling asleep or sleeping too much nearly every day. Resident #4 experienced feeling down, depressed or hopeless and felt tired or had little energy for more than half the days during the review period. B. Record review Resident #4 had a provisional PASRR completed on 8/18/23. He had a PASRR Level I identification screen approved on 4/18/24 that documented a PASRR Level II was needed. -A review of Resident #4's EMR did not reveal documentation that a Level II PASRR had been completed. IV. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnosis included recurrent major depressive disorder. The 5/21/24 MDS assessment documented Resident #18 was cognitively intact with a BIMS score of 14 out of 15. Resident #18 experienced feeling down, depressed or hopeless and felt tired or had little energy for more than half the days during the review period. B. Record review Resident #18 had a PASRR Level I identification screen approved on 8/11/23 that documented a PASRR Level II was needed. -A review of Resident #18's EMR did not reveal documentation that a Level II PASRR had been completed. V. Resident #22 A. Resident status (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22, age, 84, was admitted on [DATE] and passed away at the facility on 6/9/24. According to the June 2024 CPO, diagnoses included major depressive disorder. The 3/15/24 MDS assessment documented Resident #22 was cognitively intact with a BIMS score of 15 out of 15. Resident #22 experienced feeling down, depressed or hopeless, felt tired or had little energy, had a poor appetite or overate, felt bad about himself and had trouble concentrating nearly every day. B. Record review Resident #22 had a PASRR Level I identification screen approved on 3/14/24 that documented a PASRR Level II was needed. -A review of Resident #22's EMR did not reveal documentation that a Level II PASRR had been completed prior to Resident #22 passing away on 6/9/24. VI. Staff interviews The social services director (SSD) was interviewed on 6/11/24 at 9:53 a.m. The SSD said if a resident was admitted with a provisional PASRR she had 30 days to submit the PASRR Level I. The SSD said if a PASRR Level II was needed, she scheduled the assessment with the evaluator and the resident. The SSD said she identified a problem with the PASRRs that were not followed up on accurately when she completed her quarterly report. She said she was learning the PASRR system because she was from another state and needed more education for the process. The SSD said it was important to complete the PASRRs and the evaluations to ensure the residents received the care and special treatment they needed for their mental health. VII. Facility follow-up The NHA provided follow-up on 6/17/24 at 4:27 p.m. The follow-up information included the following information: Resident #26 had a new PASRR submitted on 6/17/24 (after the survey exit) and was waiting for an assessor to schedule the PASRR Level II evaluation. Resident #36 had a new PASRR submitted on 6/14/24 (after the survey exit) and had an evaluation scheduled for 6/18/24 at 10:00 a.m. Resident #4 had a new PASRR submitted on 6/14/24 (after the survey exit) and had an evaluation scheduled for 6/17/24 at 2:00 p.m. Resident #18 had a new PASRR submitted on 6/13/24 (after the survey exit) and had an evaluation scheduled for 6/17/24 at 2:00 p.m. Resident #22 passed away on 6/9/24 and a new PASRR was not able to be submitted.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to ensure a discharge summary was in place for one (#65) of three residents reviewed for discharge out of 45 sample residents. Specifically, the facility failed to ensure Resident #65's discharge summary included a recapitulation of the resident's stay and a complete final summary of the resident's status. Findings include: A. Resident status Resident #65, age 83, was admitted on [DATE] and discharged to another long-term care facility on 4/5/24. According to the April 2024 computerized physician orders (CPO), diagnoses included hyperkalemia (higher than normal potassium in the blood), benign prostatic hyperplasia (enlargement of the prostate) and major depressive disorder. The 2/6/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required supervision with activities of daily living (ADL). B. Record review The discharge summary dated 4/5/24 documented the resident was discharged to another long-term care facility. -The discharge summary was not completed in its entirety. The following information was missing from the discharge summary: -Physical and mental functional status including activities of daily living (ADLs); -Continence status; -Vision status; -Behavior; -Cognitive status; and, -Pertinent lab results. C. Staff interviews (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service director (SSD) was interviewed on 6/11/24 at 11:00 a.m. The SSD said Resident #65 was discharged to another long-term care facility per the family's request. She said when a resident was discharged from the facility, a discharge summary was completed by the interdisciplinary team (IDT). She said each member of the IDT was responsible for completing their section of the discharge summary. The corporate clinical manager (CCM) was interviewed on 6/11/24 at 5:28 p.m. The CCM said, for a discharge summary, each member of the IDT was responsible for completing their section for the recapitulation of the resident's stay. The CCM reviewed Resident #65's discharge summary and said several areas on the discharge summary had not been completed. She said she would provide education to the IDT.

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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** 20287 Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain vision abilities for one (#19) of one resident reviewed for vision problems out of 45 sample residents. Specifically, the facility failed to ensure Resident #19 was assisted to receive his new glasses. Findings include: I. Resident #19 A. Resident status Resident #19, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease with exacerbation and malignant neoplasm of the prostate. The 4/30/24 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required substantial assistance with activities of daily living (ADL). The MDS assessment documented the resident had adequate vision with eye glasses. B. Resident interview Resident #19 was interviewed on 6/6/24 at 9:52 a.m. Resident #19 said he needed to get new glasses as his current glasses were out of date. He said his vision was blurry. He said he had seen an eye doctor but the facility had not assisted him with getting new eyeglasses. C. Record review The 2/8/23 eye consult office visit revealed Resident #19 had an eye exam. The note documented the resident needed to have his glasses upgraded with a new prescription. The note had a new prescription for eyeglasses with it. The prescription was signed by the physician on 2/8/23. -Review of Resident #19's electronic medical record (EMR) did not reveal documentation to indicate the resident had his eye glasses replaced D. Interviews The social service director (SSD) was interviewed on 6/10/24 at 12:15 p.m. The SSD said she would review the record to check to see if the resident received his new glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The regional operations manager (ROM) was interviewed on 6/10/24 at 12:45 p.m. The ROM said after reviewing the medical record, it was determined the resident was seen by the eye doctor on 2/8/23, however, the facility missed obtaining the new eyeglasses for Resident #19. He said the SSD made an appointment (during the survey) for the resident to get his new glasses as the prescription was still in good standing. The appointment was scheduled within the next week.

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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** 50314 Based on record review and interviews, the facility failed to ensure one (#54) of three residents with limited range of motion received appropriate treatment and services out of 45 sample residents. Specifically, the facility failed to provide restorative therapy services to Resident #54. Findings include: I. Professional Reference According to the American Association of Post-Acute Nursing (AAPACN) Guidelines for Restorative Nursing Programs, retrieved on 6/17/24 from aapacn.org/restorative-programs-guide/, The risk for functional decline in long term care residents is a serious issue that often leads to falls, pressure ulcers/injuries, weight loss, depression, and other negative outcomes. To ensure quality outcomes and to comply with federal regulation, nursing facilities must have a comprehensive and effective restorative therapy program that encourages each resident's highest level of function. II. Resident #54 A. Resident status Resident #54, age greater than 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), diabetes and generalized muscle weakness. The 4/9/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required set-up or clean-up assistance with eating. The resident required substantial or maximum assistance with transfers, showers, toileting and personal hygiene. B. Resident interview Resident #54 was interviewed on 6/5/24 at 10:14 a.m. Resident #54 said she was not receiving restorative therapy services to prevent physical decline. Resident #54 said she felt like she had become weaker since her readmission to the facility on [DATE]. Resident #54 said she wanted to work towards walking more so she could be more independent in her room. Resident #54 said she felt both worried and sad that she was becoming more dependent on staff for assistance when she would rather work with the therapy department to keep as much of her independence as possible. C. Record review (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interdisciplinary team (IDT) conference review summary was documented on 1/19/24 at 1:24 p.m by the social services director (SSD). The assessment documented the resident was not receiving restorative therapy services. A physical therapy discharge summary dated, 1/26/24, documented that physical therapy services ended because of a lack of payment source for the resident's physical rehabilitation services. The discharge summary recommended a home exercise program and a restorative therapy program for the resident. The discharge summary documented Resident #54 and facility staff were educated on positioning maneuvers, pressure relieving techniques, safe transfer techniques, assistive device use and compensatory strategies in order to facilitate functional independence for Resident #54. -A review of the June 2024 CPO revealed the resident did not have an order for restorative nursing services. III. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 6/10/24 at 10:38 a.m. CNA #2 said she did not know what restorative therapy services were. CNA #2 said she knew physical therapy was provided in the building, but was unsure who provided restorative therapy services to residents. Licensed practical nurse (LPN) #6 was interviewed on 6/12/24 at 10:29 a.m. LPN #6 said she knew what restorative therapy services were, but she was not aware of any restorative therapy services being provided in the building. LPN #6 said Resident #54 was not receiving restorative therapy services. LPN #6 said Resident #54 did not have a physician's order for restorative therapy services. The physical therapist (PT) was interviewed on 6/11/24 at 1:19 p.m. The PT said restorative therapy services were recommended for residents whenever physical therapy ended for a resident without any expectation of improvement. The PT said she had started working at the facility in March 2024 and did not know anything about residents in the facility before that time. The PT said no one in the physical therapy department had worked with Resident #54 in the last several months. The PT said she did not know the resident wished to continue working with restorative therapy services to maintain her current level of function. The director of rehabilitation (DOR) was interviewed on 6/12/24 at 12:24 p.m. The DOR said restorative therapy services were an important maintenance program to maintain a resident's current level of function and to prevent further physical decline. The DOR said the therapy department at the facility did not complete restorative therapy services, but the therapy department would provide recommendations to the nursing staff for residents to receive restorative therapy services, which was documented in the residents' medical record. The DOR said restorative therapy services would have helped prevent physical decline for Resident #54. (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 nursing (DON) was interviewed on 6/12/24 at 1:05 p.m. The DON said restorative therapy services were important to maintain a resident's baseline physical function. The DON said Resident #54 did not receive restorative therapy services. The DON said there was no documentation in Resident #54's medical record to indicate she received restorative therapy services. The DON said the facility had experienced significant turnover in the physical therapy department and recommendations for restorative therapy services were not communicated effectively due to the turnover. -However, PT discharge summary documentation revealed the PT department had communicated and educated nursing staff on the restorative therapy services Resident #54 required on 1/26/24. The nursing home administrator (NHA), the regional operations manager (ROM), and the DON were interviewed together on 06/12/24 at 4:32 p.m. The NHA said the facility had identified restorative therapy services as an area of needed improvement within the facility quality assurance and performance improvement (QAPI) committee. The DON said the facility had been talking about the need to properly offer and complete restorative therapy services for residents in the facility. The DON said she had been working to provide restorative therapy services education to nursing staff. The ROM said the DOR identified a need to hire a restorative therapy services aide to ensure restorative therapy services were appropriately completed. The DON said a restorative therapy services aide would be starting in the facility in July 2024 to provide restorative services to residents.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48412 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for four out of five staff reviewed. Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #2, CNA #5, CNA #4 and CNA #3. Findings include: I. Record review CNA #2 (hired on 5/16/23), CNA #5 (hired on 8/18/21), CNA #4 (hired on 4/6/17), and CNA #3 (hired on 2/1/23) did not have an annual performance review completed. The CNAs did not have an in-service education plan based on the outcome of the review. II. Staff interviews The director of nursing (DON) was interviewed on 6/6/24 at 4:25 p.m. The DON said she was the staff development coordinator because the facility just hired someone who was still in training. The NHA and the DON were interviewed together on 6/11/24 at 4:10 p.m. The DON said she was unaware when she provided CNAs with in-service training she needed to base the in-service training on the CNAs performance reviews. The NHA said staff training was an area the facility needed to improve on and it was a work in progress. The NHA said the facility provided each staff member with a performance evaluation and the staff member completed the self-evaluation before they met with the DON. The NHA said she was unsure when these were completed. The NHA said the facility wanted to hold the staff accountable for the evaluations but needed a better tracking system. CNA #5 was interviewed on 6/12/24 at 10:36 a.m. CNA #5 said she had never completed a performance evaluation at the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48412 Based on observations, interviews and record review, the facility failed to post nurse staffing information daily. Specifically, the facility failed to: -Post the total number of actual hours worked by the licensed and unlicensed staff directly responsible for resident care per shift; and, -Maintain staffing data for 18 months as required. Findings include: I. Observations Observations in the facility on 6/5/24 at 10:00 a.m. revealed no nurse staffing posting. Observations in the facility on 6/6/24 at 12:00 p.m. revealed no nurse staffing posting. II. Record review A request for the required May 2023 to May 2024 staff posting was requested on 6/6/24 at 4:25 p.m. The DON said the facility had not utilized staff posting in over four years (see interview below). III. Staff interviews The director of nursing (DON) was interviewed on 6/6/24 at 4:25 p.m. The DON said she was covering as the staff development coordinator until the new staff development coordinator, who was hired, was fully trained. She said she used a sheet similar to the daily working schedule and had them posted at each nurses' station. The DON said she was unaware that the staffing data needed to be posted in a visible area for residents and families. She said when she was a floor nurse the night shift nurse filled out the staffing data posting. She said that form had not been used in over four years.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on interviews and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications for one (#22) of five residents reviewed for medications out of 45 sample residents. Specifically, the facility failed to ensure as needed (PRN) psychotropic medications were discontinued after 14 days for Resident #22. Findings include: I. Resident status Resident #22, age over 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder and chronic systolic (congestive) heart failure. The 3/15/24 minimum data set (MDS) assessment documented Resident #22 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented Resident #22 had felt down, depressed or hopeless, felt tired or had little energy, had a poor appetite, felt bad about himself and had trouble concentrating nearly every day during the assessment look back period. II. Record review Review of Resident #22's June 2024 CPO revealed the following physician's order: Lorazepam (an anti-anxiety medication) 2 milligrams (mg)/milliliters (ml), give 0.5 ml every hour as needed for shortness of breath for 90 days, ordered on 6/8/24 with an end date of 9/6/24. III. Staff interviews The director of nursing (DON), the nursing home administrator (NHA) and the corporate consultant (CC) were interviewed on 6/11/24 at 4:42 p.m. The DON said she was not sure how long PRN psychotropic medications were ordered for but thought it was for 90 days or six months. The DON asked the CC how long PRN psychotropic medications were ordered for. The CC said psychotropic medications should only be ordered for 14 days at a time unless the resident's physician specified a reason why the medication was ordered for more than 14 days. The CC said she there should have been a rationale documented for Resident #22's order if the physician wanted it to be ordered for 90 days and she did not know why there was not one documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the facility recently switched pharmacies and she was unaware if the pharmacist reviewed PRN psychotropic medications to see if they were ordered for the appropriate length of time. The DON said she entered all of the medication orders for the residents at the facility. The DON said she was going to reach out to the medical director (MD) and get the orders for PRN psychotropic medications corrected to the appropriate length of 14 days. The pharmacist (PH) was interviewed on 6/12/24 at 10:39 a.m. The PH said PRN psychotropic medications should be ordered for 14 days at a time and required the physician to see the resident in order to prescribe the medication again. He said, when he reviewed residents' medications, if he saw a medication ordered for 90 days he requested the physician to change the order to 14 days or document a clinical reason for the 90 days order. The PH said he was behind schedule on his resident medication reviews and therefore he had not yet seen the 90-day PRN order for Resident #22's lorazepam.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored in accordance with professional standards in one of two medication storage rooms and one of two medication storage carts. Specifically, the facility failed to: -Ensure all medications and biologicals were stored appropriately in a secure location; and, -Maintain a medication refrigerator temperature log for one of three medication refrigerators. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), Elsevier, St. Louis Missouri, pp. 1976, retrieved on 6/19/24, All drugs are secured in designated areas only accessible to nurses. II. Observations On 6/10/24 at 8:59 p.m., the central hall medication cart was observed in the unlocked position. At 9:02 p.m., registered nurse (RN) #1 approached the medication cart and locked it. III. Record Review The East nursing station refrigerator medication log records from 3/1/24 to 6/10/24 were obtained from the nursing home administrator (NHA) on 6/11/24 at 1:51 p.m. Out of 102 days of documentation opportunities, refrigerator temperatures were documented on 88 of those days. The East medication refrigerator temperatures were documented on only one day (5/31/24) between 5/28/24 and 6/5/24, a nine day period of time. IV. Staff Interviews RN #1 was interviewed on 6/10/24 at 9:24 p.m. RN #1 said medication carts should always be locked when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) # 9 was interviewed on 6/11/24 at 10:18 a.m. LPN #9 said medication carts should always be locked when not in use. LPN #9 said night shift nurses were responsible for observing and documenting medication refrigerator temperatures. LPN #9 said it was important for medication refrigerator temperatures to be checked to ensure medications stored within the refrigerators remained safe and effective for resident use. The director of nursing (DON) was interviewed on 6/12/24 at 3:18 p.m. The DON said the night shift nurses were responsible for recording medication refrigerator temperatures.The DON said medication carts should always be locked when not in use. The DON said more education was needed for bedside nursing staff regarding locking medication carts appropriately. The nursing home administrator (NHA) was interviewed on 6/12/24 at 3:40 p.m. The NHA said the refrigerator temperature logging concern was originally identified as a problem in the facility on 5/8/24, and the facility put a performance improvement plan in place at that time. The NHA said the plan included new colorful signage for temperature logging and identifying night shift nurses as responsible for logging temperatures for medication refrigerators. The NHA said the medication refrigerator temperatures should be logged every day. -However, the facility failed to document medication refrigerator temperatures for eight of the 28 days after the performance improvement plan was initiated on 5/8/24.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews the facility failed to ensure two (#62 and #4) of six residents with an order for an altered mechanical soft texture, out of 45 sample residents received food and fluids prepared in a form designed to meet their needs per physician orders. Specifically, the facility failed to provide Resident #62 and Resident #4 the correct mechanically altered diet texture. Findings include: I. Professional reference The Common Ground Between National Dysphagia Diet (NDD) and International Dysphagia Diet Standardisation Initiative (IDDSI), reviewed July 2021, retrieved on 6/17/24 from https://iddsi.org/IDDSI/media/images/CountrySpecific/UnitedStates/NDD-to-IDDSI-Implementation.pdf . It read in pertinent part NDD of 2002 is being replaced by the IDDSI Framework, founded in 2013. This is the only professionally recognized and supported diet framework as of October 2021. NDD level three dysphagia advanced is now IDDSI soft and bite-sized level six. The NDD description stated bite-sized, soft, moist and not sticky. However, bite-sized guidelines were larger than the typical diameter of an airway. The IDDSI name of soft and bite-sized is more descriptive of what food consistency the kitchens should produce. The Soft and Bite-sized Framework, revised January 2019, retrieved on 6/14/24 from, https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/6_Soft_Bite_Sized_Adult_consumer_handout_30Jan2019.pdf. It read in pertinent part, Level six, soft and bite-sized foods: -Soft, tender and moist, but with no thin liquid leaking or dripping; -Ability to bite off a piece of food is not required; -Ability to chew bite-sized pieces so that they are safe to swallow is required; -Bite-sized piece no bigger than one and a half centimeters by one and a half centimeters (half an inch by half an inch) in size; -Food can be mashed or broken down with pressure from a fork; and -A knife is not required to cut this food. Examples of soft and bite-sized food for adults: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No regular bread due to a high choking risk; and Food characteristics to avoid are soup with pieces of food, cereal with milk, nuts, raw vegetables, dry cakes, bread, dry cereal, steak, pineapple, candies, marshmallows, raw carrot, raw apple, popcorn, peas, grapes, chicken or salmon skin, meat with gristle, overcooked oatmeal, lettuce, cucumber, uncooked baby spinach, crisp bacon, etc. II. Resident #62 A. Resident status Resident #62, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician order (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (not enough oxygen going through the body), dysphagia (difficulty swallowing) and dysphagia oropharyngeal phase (difficulty swallowing in the throat and mouth). The 5/13/24 minimum data set (MDS) assessment documented Resident #62 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #62 experienced coughing or choking episodes during meals or when she swallowed her medications. The resident was prescribed a mechanically altered diet. B. Observations and interviews During a continuous observation during the lunch meal on 6/10/24, beginning at 11:18 a.m. and ending at 12:49 p.m., the following was observed: At 11:48 a.m. the dietary director (DD) told the cook (CK) Resident #62' s meal tray was ready to be served. The plate consisted of a sandwich cut in half and soup. The resident' s meal ticket documented she was on a mechanical soft diet. The DD said Resident #62 refused to eat the mechanically altered food so he served her regular food. The DD said he used to offer Resident #62 the mechanical soft food first then would make her a new plate but he wanted to cut back on food waste. The DD said he knew the resident would refuse the mechanically altered diet, so he did not offer it to the resident. C. Record review The June 2024 CPO revealed Resident #62 had a physician' s order for a mechanical soft diet with thin liquids, ordered on 5/27/24. Resident #62' s care plan, revised 5/7/24, documented she was at risk for aspiration, choking or difficulty swallowing related to a diagnosis of dysphagia. An intervention was documented as serving her diet as ordered. III. Resident #4 A. Resident status (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included sequelae (residual effects) of cerebral infarction (stroke), dysarthria (difficulty speaking) following cerebral infarction, acute respiratory failure with hypoxia (not enough oxygen throughout the body), dysphagia oropharyngeal phase and dysphagia following cerebral infarction. The 4/30/24 MDS assessment documented Resident #4 had moderate cognitive impairments with a BIMS score of 12 out of 15. Resident #4 had no swallowing problems. Resident #4 was prescribed a mechanically altered diet. B. Observations and interviews During a continuous observation during the lunch meal on 6/10/24, beginning at 11:18 a.m. and ending at 12:49 p.m., the following was observed: At 12:18 p.m. the CK began plating Resident #4' s meal.The meal included regular texture spaghetti with two whole meatballs and half of a slice of garlic toast. Resident #4' s meal ticket documented the resident was prescribed a mechanical soft diet. The CK put Resident #4' s tray in the hot box to be served to the resident in his room. At 12:20 p.m. upon prompting, the CK removed Resident #4' s plate from the hot holding box and the DD made Resident #4 a new plate. The CK put the new tray back into the hot holding box. The DD said he did not realize he was serving an incorrect texture for Resident #4. C. Record review The June 2024 CPO revealed Resident #4 had a physician' s order for a mechanical soft diet with thin liquids, ordered on 8/21/23. Resident #4' s care plan, revised 8/30/23, documented Resident #4 was at minimal nutritional risk, was independent with eating and made his needs known. Interventions included observing for signs or symptoms of dysphagia which included pocketing food, coughing, choking, drooling or holding food in his mouth. IV. Staff interviews The nursing home administrator (NHA), the director of nursing (DON) and the corporate consultant (CC) were interviewed together on 6/11/24 at 4:42 p.m. The DON said all physician' s orders entered into the resident' s electronic medical record (EMR) needed to be followed. The DON said a mechanically altered diet was ordered to assist residents with difficulty swallowing. The NHA said mechanical soft diets needed to be followed for the safety of the residents. The NHA said she was unaware of any residents who refused their textures and said she was going to look into it. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The registered dietitian (RD) was interviewed on 6/12/24 at 11:47 a.m. The RD said all diet orders needed to be followed by the staff. She said mechanically altered diets were followed because of swallowing concerns and to prevent aspiration or choking. The RD said if a resident refused their prescribed diet texture there needed to be an interdisciplinary team (IDT) meeting to discuss other approaches. The RD said she was unaware of any residents currently at the facility who consistently refused their diets. The DD and the NHA were interviewed together on 6/12/24 at 1:17 p.m. The DD said he needed to provide more training to the dietary department regarding mechanically altered diets. He said he was going to ensure all diet orders were followed by the dietary staff and if the resident refused their mechanically altered diet he was going to make sure it was being tracked in the resident' s EMR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48412 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and three of three unit refrigerators. Specifically, the facility failed to: -Ensure staff followed appropriate hand washing and glove usage in the main kitchen; and, -Ensure food was labeled and stored appropriately in the main kitchen refrigerator and freezer and in three unit refrigerators. Findings include: I. Staff hand hygiene A. Professional reference According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations, retrieved on 6/24/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; after handling soiled equipment or utensils; before donning gloves to initiate a task that involves working with food; and, after engaging in other activities that contaminate the hands. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. B. Facility policy and procedure The Sanitization policy, revised November 2022, was provided by the nursing home administrator (NHA) on 6/12/24 at 1:30 p.m. It read in pertinent part, All kitchens, kitchen areas and dining areas are kept clean and free from garbage and debris. C. Observations During a continuous observation on 6/10/24, beginning at 11:18 a.m. and ending at 12:45 p.m., the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:45 a.m. the dietary director (DD) put on a pair of gloves and began plating lunch. -The DD did not wash his hands prior to putting on a pair of gloves. At 12:01 p.m. the DD plated a resident's cheeseburger using gloved hands. -The DD removed the pair of gloves and put a new pair on without performing hand hygiene. The DD proceeded to prepare 10 residents' food plates with the same gloves. -The DD used his gloved hands to pick up a slice of garlic toast for each resident's plate after touching multiple meal tickets. At 12:12 p.m. the DD placed two pieces of cheese on a hamburger patty on the flat top and used his gloved hand to push the burger down. -The DD did not change his gloves or wash his hands after touching the cheeseburger. At 12:23 p.m. the DD washed his hands for the first time and put on another pair of gloves. D. Staff interviews The DD was interviewed on 6/12/24 at 1:17 p.m. The DD said hand hygiene needed to be completed when gloves were changed, products were switched and upon entering or leaving the kitchen. The DD said he did not realize he was wearing the same pair of gloves and was touching multiple things, including clean and dirty items. II. Food storage and date marking system A. Professional reference According to the 2022 Food Code U.S. Food and Drug Administration, (1/18/23), retrieved on 6/24/24 from Chapter 3, Page 11 3-301.12, Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices and sugar shall be identified with the common name of the food. The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 6/24/24 from https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, read in pertinent part, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; or Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. The Hormel Health Labs Code Date and Handling Information, revised 2024, was retrieved on 6/24/24 from https://www.hormelhealthlabs.com/wp-content/uploads/HHL-Code-Date_Handling-Sheet-04_2024.pdf, page 12. It revealed in pertinent part, Mighty nutritional shakes have a shelf life of 14 days in the refrigerator once thawed. B. Observations On 6/5/24 at 8:55 a.m., an initial tour of the kitchen was conducted and the following was observed in the walk-in refrigerator: -A large bowl of meat and sauce did not have a label indicating what the food was and had a date of 5/28/24; -23 single-serving condiment containers with a white condiment that was unlabeled and undated; -A container of chopped lettuce that was open and undated; -A chocolate pie that was unlabeled and undated; and, -Three cartons of egg whites that were opened but were not dated. At 9:10 a.m. the following was observed in the walk-in freezer: -A puff pastry that was uncovered and undated; -A box of raw beef hamburger patties that was uncovered and undated; -A bag of frozen potatoes that were unlabeled and undated; and, -A bag of frozen egg rolls that were undated. -On 6/10/24 at 9:27 p.m. the Center hall refrigerator had seven thawed Mighty Shakes (nutritional health shakes) that were not dated. -At 9:30 p.m. the East hall refrigerator had 14 thawed Mighty Shakes that were not dated. -At 9:35 p.m. the [NAME] hall refrigerator had eight thawed Mighty Shakes that were not dated. C. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DD was interviewed on 6/12/24 at 1:17 p.m. The DD said the dietary staff were required to label all food stored in the kitchen that was not in the original packaging. The DD said the morning dietary shift stocked the refrigerator and rotated out the health shakes in the unit refrigerators. The DD said the dietary staff needed to date the health shakes when they were thawed and he was unsure how long the health shakes were good for once they were thawed. The DD said the staff followed the manufacturer's use by date that was on the health shakes. The DD said he was going to move the food delivery orders into the refrigerator and freezer himself to ensure things were labeled and dated correctly.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to meet all the requirements for the provision of hospice care for one (#19) of four residents out of 45 sample residents. Specifically, the facility failed to ensure the hospice agency notes regarding Resident #19's care were easily accessible to the facility staff in an attempt to effectively coordinate care with the hospice agency. Findings include: I. Resident #19 A. Resident status Resident #19, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD) with exacerbation and malignant neoplasm of the prostate. The 4/30/24 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required substantial assistance with activities of daily living (ADL). The assessment documented the resident was receiving hospice services. B. Resident interview Resident #19 was interviewed on 6/6/24 at 9:58 a.m. Resident #19 said he was not aware he was receiving hospice services. C. Record review The June 2024 CPO revealed a physician's order for Resident #19 to receive a hospice consultation on 1/24/24. -However, there was not a physician's order for hospice care services documented in the June 2024 CPO. The 2/11/24 care plan identified Resident #19 had an end of life care plan and received hospice services for weight loss, worsening skin integrity and abnormal breathing. Pertinent interventions included, to coordinate resident's needs with hospice staff. The care plan did not include hospice on any other part of the care plan to indicate what the hospice care team would be involved with. -The electronic medical record (EMR) failed to reveal any progress notes from the hospice services provider or a hospice care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interview The licensed practical nurse (LPN) #9 was interviewed on 6/10/24 at 3:40 p.m. LPN #9 reviewed Resident #19's EMR and confirmed there was not a physician's order for hospice services. LPN #9 said she was not aware if the resident was receiving hospice services because she could not locate any nurses notes. LPN #9 said the director of nursing (DON) would know if the resident was receiving hospice services. . The DON was interviewed on 6/10/24 at approximately 4:30 p.m. The DON said Resident #19 was receiving hospice services. She said there should be a physician's order for hospice services in the resident's EMR because she was the person who entered physician's orders for hospice services. -However, Resident #19's EMR did not include a physician's order for hospice services (see record review above). The social service director (SSD) was interviewed on 6/10/24 at 4:30 p.m. The SSD said Resident #19 was on hospice services and she was responsible for putting an end of life care plan in the comprehensive care plan. The corporate consultant (CC) was interviewed on 6/11/24 at approximately 4:00 p.m. The CC said, after talking with Resident #19's hospice services provider, she found that the hospice services agency was sending all their progress notes for Resident #19 to the facility's previous medical records director (MRD). She said the hospice services provider said they did not know there was a new MRD at the facility and they did not have the email address for the new MRD in order to know where to send Resident #19's information. The hospice certified nurse aide (HCNA) was interviewed on 6/11/24 at 12:00 p.m. The HCNA said she documented her notes in her phone and then the notes were sent over the hospice services provider. She said the hospice services provider would send the notes to the facility when they received her notes via phone. The new MRD was interviewed on 6/11/24 at 5:00 p.m. The MRD said she now had the hospice services provider's email address and the provider now had her correct email address so they could send the hospice notes for Resident #19 to her. She said she had now received all of the hospice notes for Resident #19.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, interviews and record review, 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 qualify of care, quality of life, and resident safety. Specifically, the facility's quality assurance and performance improvement (QAPI) program committee failed to effectively identify and address concerns related to residents' quality of care, quality of life, staff training and infection prevention and control. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement Program (QAPI) Analysis and Action policy, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 2:36 p.m. via email. The policy read in pertinent part, The QAPI program, overseen by the QAPI committee, is designed to identify and address quality deficiencies through the analysis of the underlying causes and actions targeted at correcting systems at a comprehensive level. The methodology for analysis and action is guided by a written QAPI plan that includes: -Definition of the problem, based on information obtained through data, self-assessment and feedback systems; -Analysis of root cause of the problem from a system's perspective; -Measurable goals or benchmarks for improvement; -To take interventions aimed at correcting the problem and achieving the state of goals or benchmarks; and, -Methods and frequency of monitoring performance improvement objectives. II. Cross-referenced citations Cross-reference F565: The facility failed to ensure effective interventions to resident council grievances of call light response time. Cross-reference F567: The facility failed to ensure proper consent and notification of spending of personal funds. (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 F580: The facility failed to ensure a resident's representative was notified after a change in condition. Cross-reference F582: The facility failed to give the proper two day notification before Medicare A benefits expired. Cross-reference F610: The facility failed to investigate a potential allegation of abuse. Cross-reference F644: The facility failed to submit a PASRR Level I based on diagnosis. Cross-reference F645: The facility failed to complete a PASRR Level II after a PASRR Level I determination. Cross-reference F661: The facility failed to ensure a discharge summary was completed after a resident was discharged . Cross-reference F685: The facility failed to ensure a resident received eye glasses after an eye exam. Cross-reference F688: The facility failed to provide restorative nursing services. Cross-reference F689: The facility failed to assess a resident after injuries were identified after a potential fall. Cross-reference F692:The facility failed to implement interventions to prevent further weight loss after a resident had significant weight loss. Cross-reference F730: The facility failed to complete annual evaluations for certified nurse aides (CNA). Cross-reference F732: The facility failed to have an accurate nursing staff posting. Cross-reference F744: The facility failed to provide adequate dementia care training for the secure unit; failed to implement a dementia care plan for refusals of food, medications, fluids and vital signs. Cross-reference F758: The facility failed to limit PRN (as needed) psychotropic medications to 14 days or have physician documentation of the rationale. Cross-reference F761: The facility failed to ensure all medications were stored appropriately and maintain medication refrigerator temperature logs. Cross-reference F804: The facility failed to serve palatable food in taste and temperature. Cross-reference F805: The facility failed to serve food according to a physician's order. Cross-reference F812: The facility failed to prepare, store and serve food in a sanitary manner. (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 F842: The facility failed to accurately document fluid intake. Cross-reference F849: The facility failed to ensure the facility received hospice notes and physician orders. Cross-reference F880: The facility failed to implement an effective infection prevention and control program, to include identifying residents who required enhanced barrier precautions, ensure personal protective equipment was available, ensure the facility had an effective water management plan, ensure resident rooms were properly sanitized, ensure residents had clean bed linens after wound dressing changes and ensure residents were offered hand hygiene before meals. Cross-reference F882: The facility failed to have an infection preventionist at least part time to run an effective infection control program. Cross-reference F908: The facility failed to ensure the use of appropriate medical grade blood pressure cuffs. Cross-reference F943: The facility failed to ensure all staff completed abuse training annually. Cross-reference F947: The facility failed to ensure CNAs received 12 hours of required training annually. Cross-reference EP004: The facility failed to ensure the emergency preparedness plan was reviewed annually. Cross-reference EP039: The facility failed to conduct emergency exercises annually. II. Interviews The NHA, the regional operations manager (ROM) and the director of nursing (DON) were interviewed together on [DATE] at 4:32 p.m. The NHA said the QAPI committee meeting was held monthly. The NHA said the meeting included the interdisciplinary (IDT) team as well as the medical director and pharmacist. The NHA said the QAPI committee identified areas of concerns, created performance improvement plans, set goals and reviewed the progress of the plans and determined if additional meetings and education were needed on the concerns and/or one-on-on interventions. The NHA said to ensure systematic change, the facility continued the conversations of the identified concern and determined if revisions to the plan were necessary. The NHA said several of the identified concerns were reviewed in the QAPI meetings but the facility had had changes to personnel and the support provided was not enough. The NHA said the facility had to make significant changes over the last few months. The NHA said the changes were underway but not as quickly as the facility would want. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ROM said the QAPI committee was not really conducting a full quality assurance review with the ongoing concerns. He said the IDT discussed several of the identified concerns in the morning stand up meetings, but not all the discussed concerns were brought to QAPI, so the breakdown of the problems did not fully occur. The ROM said the facility's QAPI plan failed. The DON said some areas of concern had been overlooked. The DON said the QAPI committee needed to look at all concerns and potential concerns with fresh eyes. The DON said the committee needed to hold each other accountable and determine what the facility could do to help each other with the identification and correction of the concerns.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50314 Based on observations and interviews, the facility failed to ensure a qualified infection preventionist (IP) was in place for providing guidance to the facility on the infection control policy and programs which had the potential to affect all 74 residents residing in the facility at the time of the survey. Specifically, the facility failed to have a designated IP who had the time necessary to properly assess, develop, implement, monitor, and manage the infection prevention and control program (IPCP) for the facility. Findings include: I. Facility policy and procedure The Infection Prevention and Control Program policy, revised October 2018, was received from the nursing home administrator (NHA) on 6/10/24 at 10:24 a.m. It documented in pertinent part, Policies and procedures reflect the current infection prevention and control standards of practice. II. Observations Observations throughout the survey (from 6/5/24 to 6/12/24) revealed multiple infection control failures within the facility. Cross-reference F880 for failure to implement an effective infection prevention and control program. III. Interviews The director of nursing (DON) was interviewed on 6/10/24 at 3:51 p.m. The DON said she was also the infection preventionist and was operating in both roles at the facility. The DON said she did not have enough time to effectively conduct the infection preventionist's responsibilities. The regional operations manager (ROM) was interviewed on 6/12/24 at 4:35 p.m. The ROM said he recognized the DON could not complete all of the infection preventionist assignments she was currently responsible for. The ROM said the facility had been working to hire another staff member to take over the role of the infection preventionist for the DON.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to maintain all mechanical, electrical and patient care equipment in safe operating condition. Specifically, the facility failed to ensure facility staff used a blood pressure cuffs which were rated for medical use. Findings include: I. Professional reference According to the [NAME] Advantage for Basic Nursing handbook, third edition, retrieved on 6/17/24 from Treas, [NAME] S., et al. [NAME] Advantage for Basic Nursing: Thinking, Doing, and Caring. F. A. [NAME] Company, 2022., Blood Pressure - Practical Knowledge, Electronic blood pressure monitors may be less accurate than those with an aneroid monitor (a manual blood pressure measuring device). To ensure accuracy, you should auscultate (listen to) a baseline blood pressure before initiating automatic monitoring. Ensure devices are rated for medical use. The width of the blood pressure cuff bladder of a properly fitting cuff will cover approximately two-thirds of the length of the upper arm for an adult, and the entire upper arm for a child. Alternative sites you can use are the forearm, thigh, or calf. However, systolic pressure may be 20 to 30 mmHg (millimeters of mercury) higher in the lower extremities than in the arms, but diastolic pressures are similar. Abnormally high or low blood pressure readings should be rechecked by the provider. According to Medaval Certified Accuracy (a company that provides accreditation, validation and equivalence services for medical devices) Equate 4000 series (UA-4000WM, retrieved on 6/20/24 from https://www.medaval.ie/resources/EN/devices/Equate-4000-Series-UA-4000WM.html, The Equate 4000 Series (UA-4000WM) is an automatic blood pressure monitor. Medaval has not found evidence proving the accuracy of its blood pressure measurement technology. Blood pressure measurements are taken from the upper arm. It is intended for self-measurement and home use. II. Observations On 6/6/24 at 9:48 a.m., licensed practical nurse (LPN) #5 was observed using an Equate model VA-4000WM blood pressure cuff to take Resident #166's blood pressure. -LPN #5 did not use a blood pressure cuff rated for medical use to obtain Resident #166's blood pressure (see professional references above and interview below). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/24 at 9:08 p.m., registered nurse (RN) #1 was observed taking Resident #51's blood pressure using an Ever Ready First Aid wrist blood pressure cuff. -RN #1 did not use a blood pressure cuff rated for medical use to obtain Resident #51's blood pressure (see professional references above and interview below). III. Staff interviews LPN #5 was interviewed on 6/6/24 at 9:49 a.m. LPN #5 said she used the Equate model VA-4000WM blood pressure cuff to obtain blood pressures on residents. RN #1 was interviewed on 6/10/24 at 9:19 p.m. RN #1 said that she used the Ever Ready First Aid blood pressure cuff to take blood pressures on residents. RN #1 said if the reading was inaccurate she would use the Equate model VA-4000WM blood pressure cuff to obtain physician-ordered blood pressures on residents. LPN #6 was interviewed on 6/11/24 at 10:18 a.m. LPN #6 said she used the Equate model VA-4000WM blood pressure cuff to obtain physician-ordered blood pressures on residents. The nursing home administrator (NHA) was interviewed on 6/11/24 at 3:41 p.m. The NHA said the Equate model VA-4000WM blood pressure cuff and the Ever Ready First Aid blood pressure cuff were not rated for medical use. The NHA said there was no documentation to indicate that the Equate model VA-4000WM blood pressure cuff and the Ever Ready First Aid blood pressure cuff were safe or accurate to use at the facility to obtain accurate resident blood pressures. The NHA said the facility was ordering new blood pressure cuffs on 6/11/24 that were rated for medical use. The NHA said new blood pressures would be obtained on all residents in the facility using blood pressure equipment rated for medical use by the end of the day on 6/11/24. The NHA said it was important to use blood pressure cuffs rated for medical use to ensure blood pressure readings could be accurately obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065286	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Ridge Post Acute	2425 Teller Ave Grand Junction, CO 81501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48412 Based on record review and interview, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property and dementia management and resident abuse prevention. Specifically, the facility failed to: -Ensure the activities assistant (AA), the cook (CK) and housekeeper (HSKP) #1 received annual training that covered abuse, reporting incidents of abuse and resident abuse prevention over the last 12 months; and, -Ensure the CK, dietary aide (DA) #2 and the maintenance assistant (MA) received annual training that covered dementia management. Findings include: I. Facility policies The Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, was provided by the nursing home administrator (NHA) on 6/6/24 at 2:40 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect, exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives provide staff orientation and training or orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management and handling verbally or physically aggressive resident behavior. The Dementia Clinical Protocol policy, revised 2001, was provided by the NHA on 6/10/24 at 1:00 p.m. It read in pertinent part, Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Additionally, performance reviews will be conducted annually and in-service education will be based on the results of the review. II. Training records A request was made for training records for the past 12 months (June 2023 to June 2024) for documentation to indicate the AA, the CK, HSKP #1 and the MA had participated in annual abuse and dementia training. The NHA provided the training records on 6/10/24 at approximately 1:00 p.m. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The training records indicated the CK, the AA and HSKP #1 had not received training that covered abuse, reporting incidents of abuse and resident abuse prevention over the past 12 months. -The training records further indicated DA #2, the CK and the MA had not received training that covered dementia management over the past 12 months. III. Staff interviews The director of nursing (DON) was interviewed on 6/6/24 at 4:25 p.m. The DON said she was the staff development coordinator because the facility hired someone who was still in training. The NHA and the DON were interviewed together on 6/11/24 at 4:10 p.m. The DON said the facility offered a four-hour dementia class to the staff and abuse training was provided through the facility' s electronic training system. The NHA said she was unaware that non-clinical staff needed abuse and dementia training. The NHA said she was unable to find the completed abuse training for the CK, the AA and HSKP #1. The NHA said she was unable to find the completed dementia training for DA #2, the CK and the MA. The NHA said she was working on a new process to track the trainings.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48412 Based on interviews and record review, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for four out of five staff reviewed. Specifically, the facility failed to ensure CNA #2, #5, #4 and #1 received 12 hours of continuing education annually in all required training topic areas, including dementia management training and resident abuse prevention training. Findings include I. Training record review Five randomly selected CNA training records were reviewed on 6/10/24. Of the five employees reviewed, four of the CNAs (#2, #5 #4 and #1) did not receive a full 12 hours of annual training. A. CNA #2 -CNA #2, hired on 5/16/23, had participated in six hours and 45 minutes of training during the annual training year. B. CNA #5 -CNA #5, hired on 8/18/21, had participated in a four-hour dementia class. The nursing home administrator (NHA) was unable to provide her complete training record, including completed training for abuse, neglect or exploitation. C. CNA #4 -CNA #4, hired on 4/6/17, had participated in four hours and 30 minutes of training during the annual training year and had no record of completing abuse, neglect or exploitation training. D. CNA #1 -CNA #1, hired on 4/6/23, had participated in six hours and 30 mins of training during the annual training year. II. Staff interviews The director of nursing (DON) was interviewed on 6/6/24 at 4:25 p.m. The DON said she was the staff development coordinator because the facility just hired someone who was still in training. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA and the DON were interviewed together on 6/11/24 at 4:10 p.m. The DON said she was unaware when she provided CNAs with in-service training she needed to document the length of the training. The NHA said staff training was an area the facility needed to improve and it was a work in progress. CNA #5 was interviewed on 6/12/24 at 10:36 a.m. CNA #5 said the staff were assigned training on the computer and she tried to complete it when she was able to. She said she completed a four-hour dementia training that she signed up for to attend.