STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations and interviews, the facility failed to ensure care for residents was provided timely and in a manner that maintained or enhanced the residents' dignity for three (#15, #69 and #64) of six residents reviewed for dignity out of 47 sample residents. Specifically, the facility staff failed to treat Resident #15, Resident #69 and Resident #64 in a dignified manner. Findings include: I. Facility policy and procedure The Quality of Life - Dignity policy and procedure, revised February 2020, was provided by the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice. Staff are expected to treat cognitively impaired residents with dignity and sensitivity. II. Resident #15 A. Resident status Resident #15, age 69, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included encephalopathy (a condition that affects the brain's function), schizophrenia and major depressive disorder. The 1/6/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) assessment score of nine out of 15. The resident required supervision to partial/moderate assistance for all activities of daily living (ADLs). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations During a continuous observation of housekeeper (HK) #1 on 2/5/25, beginning at 9:28 a.m. and ending at 10:11 a.m., the following was observed: At 9:28 a.m. HK #1 was standing in the open doorway of Resident #15's room preparing to clean the room. Resident #15 was lying in his bed in the room. HK #1 said the room was very stinky. -HK #1's comment was loud enough for it to be heard in the facility hallway. At 9:56 a.m. Resident #15 remained in his bed in his room. HK #1 said hold your nose before opening the door to Resident #15's bathroom. HK #1 said the bathroom was always bad but was especially bad today (2/5/25). HK #1 said the material on the bathroom floor was feces and Resident #15 had a problem with pooping and wiping himself. -HK #1's comment was said in a normal volume that could be heard by anyone in the room or in the hallway outside of Resident #15's room. C. Staff interviews The social services director (SSD) and the social services consultant (SSC) were interviewed together on 2/5/25 at 2:55 p.m. The SSD said HK #1 calling Resident #15's room stinky was a dignity issue. The SSD and the SSC said HK #1's comment would make them both feel awful if it was said about them. The SSD said it was already an uncomfortable situation to need someone to clean up after you. The SSD said the incident with HK #1 was an issue of failing to provide dignity and respect for to Resident #15. The environmental services director (ESD) was interviewed on 2/6/25 at 12:08 p.m. The ESD said housekeepers saying residents' rooms were stinky was not a normal practice. The ESD said the incident with HK #1 calling Resident #15's room stinky was a dignity issue. The nursing home administrator (NHA) and the CC were interviewed together on 2/6/25 at 6:53 p.m. The NHA and the CC both said calling Resident #15's room stinky was a dignity issue. The NHA said hearing a comment like that would not make him feel great and would make him feel undignified. III. Resident #69 A. Resident status Resident #69, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia and depression. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/9/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. The resident was dependent on staff for most ADLs. B. Observation On 2/3/25 at 11:45 a.m. registered nurse (RN) #7 was following Resident #69 to a chair at a table in the dining room. Resident #69 walked past the chair RN #7 intended for her to sit in and RN #7 grabbed Resident #69 by the waistband of her pants to prevent Resident #69 from continuing to walk forward. RN #7 assisted Resident #69 into the chair at the dining table using the waistband of the resident's pants to guide her. C. Staff interviews Restorative nurse aide (RNA) #1 was interviewed on 2/5/25 at 1:59 p.m. RNA #1 said if a resident was walking past the chair she was trying to have them sit in, she would ask them to sit down. RNA #1 said she would never grab onto a resident's clothes to stop them. RNA #1 said if she did not have eye contact with the residents, it could be difficult to get them to understand what she wanted them to do. RNA #1 said the nursing staff had to make eye contact, face the resident and walk with them wherever they were supposed to go. Certified nurse aide (CNA) #5 was interviewed on 2/5/25 at 2:21 p.m. CNA #5 said if a resident was walking past a chair she wanted them to sit in, she would make sure she talked to them so the resident knew what she was doing. CNA #5 said she would never grab a resident by their clothes and tell them to sit somewhere. CNA #5 said it was not appropriate to grab a resident by their clothes. CNA #5 said if she grabbed a resident by their clothes, they could get mad. The SSD and the SSC were interviewed together on 2/5/25 at 2:55 p.m. The SSD said when nursing staff were trying to get a resident to sit down, they should be patient and give the resident a reason for why they were redirecting them. The SSD said the nursing staff should talk to the residents and make them feel comfortable. The SSC said she would not want someone to grab onto her clothes. The SSC said the nursing staff were not trained to grab residents' clothes, but to use a gait belt and to guide the residents wherever they needed to go. The NHA was interviewed on 2/6/25 at 6:53 p.m. The NHA said the nursing staff should guide residents verbally and show them the chair if the staff member needed them to sit somewhere. The NHA said it would not be okay for a nurse to grab a resident by the waistband of the pants. The NHA said he would not appreciate it if someone grabbed him by the waistband of his pants to get him to sit down. 51163 IV. Resident #64 A. Resident status (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #64, age 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included Alzheimer's disease, metabolic encephalopathy and degenerative disease of the nervous system. The 1/17/25 MDS assessment revealed Resident #64 had moderate cognitive impairment with a BIMS score of nine out of 15. The resident was independent with the majority of his ADLs, but he required supervision or touching assistance for showering and personal hygiene. B. Observations On 2/3/25 at 9:55 a.m. Resident #64 was walking towards his room wearing a windbreaker type jacket with stains and food spills down the front of it and a heavier leather jacket with a large tear on the left sleeve. He was wearing two pairs of pants. His outer pants were falling down and were stained on the front and backside. On 2/4/25 at 10:24 a.m. Resident #64 was wearing the same stained pants, shirt and jackets as the day before (see 2/3/25 observation above). On 2/5/25 at 10:29 a.m. Resident #64 was wearing the same clothes as the previous two days, however, the resident's pants were inside-out. On 2/5/25 at 10:45 a.m. Resident #64 was walking down the hall and his pants fell completely to the floor. The resident pulled his pants back up and tried to walk with his four-wheel walker while holding his pants up. On 2/5/25 at 11:09 a.m. the NHA told Resident #64 that he would help him with his pants and belt, after seeing him struggling with his pants falling all the way to the floor and trying to tighten his belt. On 2/5/25 at 11:12 a.m. Resident #64 and the NHA were observed leaving Resident #64's room. The resident's belt appeared to be re-looped, however, his pants were still on inside-out. On 2/5/25 at 11:29 a.m. the director of medical records (DMR) was offered Resident #64 a clean pair of pants. On 2/5/25 at 11:39 a.m. the DMR, who was a CNA, was observed with new clothing for Resident #64. She assisted Resident #64 to the shower room and was heard telling him that they were going to use the shower room because maintenance was in his room fixing something. On 2/5/25 at 11:53 a.m. Resident #64 and the DMR came out of the shower room. Resident #64 was wearing a completely new outfit, including a new sweatshirt that zipped up the front. The DMR bagged up the resident's dirty clothes and put them in the soiled linen container. She then assisted the resident to the dining room for lunch. C. Record review (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, revised 7/12/24, revealed Resident #64 perseverated on thinking that people would go into his room and mess with his things with no indication that anyone had been in his room. At times, he had delusions that people were rude to him when they had not been around him. Interventions included, if appropriate, explaining why his behaviors were inappropriate, redirecting him from the situation, removing him from the situation and thoroughly investigating any claims of anyone going into his room. D. Staff interviews CNA #9 was interviewed on 2/6/25 at 2:00 p.m. CNA #9 said staff had to be very careful with Resident #64 because they did not want to violate his rights. He said Resident #64 could be very particular about who went into his room and he was resistant to allowing help. CNA #9 said when he saw the resident wearing soiled clothes, he talked to him and asked him to change his clothes, but he could be very resistant to changing his clothes. CNA #9 said it was a dignity issue when Resident #64 was walking around in dirty clothing and his pants were falling down. He said if it were him, he would feel embarrassed. The DMR was interviewed on 2/6/25 at 2:36 p.m.The DMR said Resident #64 was normally very resistant to care, but she had gone to a dementia training in October 2024 and was able to use those resources from the training to get him to change his clothes. She said she had noticed that his clothes were too small and she was able to get him some clothes that fit better from the facility's donated clothes. The DMR was interviewed again on 2/6/25 at 3:27 p.m.The DMR said she got her dementia training from a different facility where she worked as a CNA. She said she told the NHA and the interdisciplinary team (IDT) about how she was able to get Resident #64 to change his clothes. She said she spoke to social services about getting him some clothes that fit him and a new jacket that was not torn. The NHA was interviewed on 2/6/25 at 7:12 p.m. The NHA said Resident #64's willingness to change his clothes was inconsistent. He said Resident #64 could be very reactive to who was working with him and the staff had to be very careful with him. He said Resident #64 was previously homeless and had a tendency to hoard things so the facility had to find the right person to assist him with certain things. He said that the facility would care plan the DMR's approach to working with Resident #64 and educate the staff that worked with him about the effective approach.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to ensure one (#24) of one resident out of 47 sample residents were provided prompt efforts by the facility to resolve a grievance. Specifically, the facility failed to provide prompt resolution to grievances for Resident #24. Findings include: I. Facility policy and procedure The Grievances policy and procedure, dated 5/8/23, was provided via email by the nursing home administrator (NHA) on 2/6/25 at 8:08 p.m. It read in pertinent part, The resident, or person acting on behalf of the resident, will be informed of the investigation's findings and any corrective actions recommended, within five working days of filing the grievance or complaint. II. Resident #24 A. Resident status Resident #24, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder and postencephalitic parkinsonism (a Parkinson's disorder that develops after an inflammation to the brain). The 11/30/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He required substantial/maximal assistance with toileting and personal hygiene. B. Resident interview Resident #24 was interviewed on 2/3/25 at 1:37 p.m. Resident #24 said he had been missing four pairs of pants for a while. He said he spoke with the NHA and social services about it and was told the facility was only going to replace two pairs of pants. He said he hand delivered his own clothes to the laundry so he knew the pants were lost somewhere in the laundry. He said the facility had not yet replaced any of his pairs of pants. Resident #24 was interviewed a second time on 2/6/25 at 2:00 p.m. Resident #24 said the facility told him they would replace all four pairs of his pants and he was happy with the resolution. C. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/9/24 grievance form filed by Resident #24 documented he was missing two pairs of pants after the pants were sent to the laundry and were not returned. It documented follow up by the facility with the laundry department and indicated they were unable to locate his pants. It documented Resident #24 refused staff help to look for the pants in his room. The grievance form was not signed by Resident #24. The form was signed by the NHA, but there was no date to indicate when the NHA signed it. The 1/29/25 grievance form filed by Resident #24 documented he was missing two pairs of pants. It documented that the social services director (SSD) searched the room and could not find the pants in his closet. It documented that his last inventory sheet had four pairs of pants. The NHA approved purchasing four new pairs of pants for the resident. The form was signed by Resident #24 and the NHA on 2/3/25, during the survey. D. Staff interviews The social services consultant (SSC) was interviewed on 2/6/25 at 1:10 p.m. The SSC said that grievance forms were at the front of the building and could be filled out by residents or staff members and be submitted anonymously. The SSC said social services started the grievance process and then forwarded it to the appropriate department to follow up on the concern. She said grievances were also discussed in the morning meetings and forwarded to the appropriate department for follow up and a resolution to the grievance should be reached with the resident within 72 hours of the date the grievance was filled out. The NHA was interviewed on 2/6/25 at 1:25 p.m. The NHA said he had been at the facility for two years and Resident #24 had a pattern of asking the facility to replace his pants since 2017. He said the resident had multiple inventory lists and it had been unclear which inventory list he had been working off of. He said the grievance process for the missing pants had begun in September 2024. He said the facility had not been successful in finding the missing pants and did not come to a successful resolution with Resident #24. He said the issue came up again recently, and this time they were able to successfully resolve the issue with the resident. The NHA said the facility would be purchasing four new pairs of pants for Resident #24.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure two (#77 and #69) of eight residents reviewed for abuse out of 47 sample residents were kept free from abuse. Specifically, the facility failed to: -Protect Resident #77 from verbal abuse by Resident #23; and, -Protect Resident #69 from physical abuse by Resident #235. Findings include: I. Facility policy and procedure The Abuse Policy, dated 5/3/23, was provided by the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Identification of abuse shall be the responsibility of every employee. If abuse happens: separate the assailant from the victim, isolate the assailant to protect others, assess and treat the victim, and notify the abuse coordinator. II. Incident of verbal abuse of Resident #77 by Resident #23 A. Observations During a continuous observation of the lunch meal service on 2/3/25, from 11:35 a.m. to 1:34 p.m., the following was observed: At 11:35 a.m. Resident #77 and Resident #23 were talking to each other and were in a disagreement. Resident #77 told Resident #23 she should be in hell. Resident #23 said she did not want to sit at the table anymore. Resident #23 was sitting at a table alone and facing the wall and Resident #77 was sitting at another table a few feet away from Resident #23. At 11:45 a.m. Resident #23 told Resident #77 to shut up and that she would kick her explicit word. -Two nursing staff members were in the dining room at the time and were talking about something on the news. They did not address Resident #77 or Resident #23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:02 p.m. Resident #23 held her hand in a fist and directed the gesture at Resident #77, who was able to see the gesture. At 12:06 p.m. Resident #23 again held her hand in a fist and directed the gesture at Resident #77. Resident #23 said she would knock her so she would not get up. Resident #23 then told Resident #77 to go back to where she came from and called her a monkey. Resident #77 said Resident #23 was bad to her and was talking about her country. Resident #77 was upset and said she wanted Resident #23 to be moved somewhere else. Restorative nurse aide (RNA) #1 went over to Resident #77 and Resident #23 and started talking to each resident individually. RNA #1 asked Resident #77 if she wanted to move seats so she would not be next to Resident #23. RNA #1 then returned to assisting residents during the lunch service and Resident #23 and Resident #77 remained in the same spots. At 1:55 p.m. Resident #77 was in the hallway talking with the social services director (SSD). Resident #77 told the SSD that someone was mean to her during lunch. Resident #77 said someone made her cry and was bad. B. Facility incident report The facility incident report, dated 2/4/25 at 4:00 p.m., was provided by the nursing home administrator (NHA) on 2/6/25 at 2:48 p.m. The report revealed the following: On 2/3/25 at 12:15 p.m. Resident #23 and Resident #77 were sitting at different tables in the dining room. Without any noticeable provocation, Resident #23 began to call Resident #77 explicit names. Resident #77 was upset by this and began to argue with Resident #23, asking what she did to her and why she was calling her those names. Neither resident left their table. Staff intervened and calmed both residents down. The alleged victim and assailant were interviewed, along with the six closest residents to the area where the event took place, and six staff members were also interviewed. Video of the incident was reviewed and Resident #77 and Resident #23's care plans were reviewed. Resident #23 was unable to recall the incident. Resident #77 was interviewed on 2/4/25 at 4:30 p.m. by the SSD. Resident #77 said she and Resident #23 were sitting at separate tables in the dining room and waiting for lunch to be served when, without warning, Resident #23 started yelling out curses. Resident #77 said she did not like that and told her to stop and that she had not done anything wrong. Resident #77 said the staff intervened and calmed Resident #23 down. Resident #77 said she was not frightened or fearful at the time or afterward. RNA #1 was interviewed on 2/4/25 at 6:00 p.m. by the NHA. RNA #1 said she heard Resident #23 start saying expletives and nasty things, and Resident #77 did not like it and told her how she felt. RNA #1 said Resident #77 did not say anything back to Resident #23, but just said she did not do anything wrong and asked why she was talking to her that way. RNA #1 said she comforted Resident #23 and calmed her before checking on Resident #77, who said she was okay. Six residents were interviewed, none of which could recall any altercation that had taken place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Video footage of the incident was reviewed by the NHA and revealed at 11:55 a.m. Resident #77 picked up a straw from the straw dispenser on Resident #23's dining table. At 11:57 a.m. Resident #23 started to talk, then stopped. At 12:05 p.m. Resident #23 started to yell something in the general direction of Resident #77 who was sitting approximately six feet away. Resident #77 seemed to respond and gestured with her hands. RNA #1 walked over and spoke with Resident #23, who then calmed down and returned her attention to the dining table. RNA #1 then checked on Resident #77 who had turned back to her table. The facility concluded the allegation of verbal abuse was unsubstantiated. Resident #23 often responded to internal stimuli/confusion by calling out or talking, sometimes with profanity. The facility determined Resident #23 was not addressing Resident #77 when she began cussing in the dining room. Resident #77 also did not feel frightened or threatened at any point. -However, verbal abuse occurred due to Resident #23, who had a history of verbal aggression towards others, calling Resident #77 derogatory names and cursing at her. C. Resident #23 (assailant) 1. Resident status Resident #23, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with other behavioral disturbance and depression. The 11/12/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. The resident was dependent on staff for most activities of daily living (ADL). The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Record review The mood care plan, revised 8/23/22, revealed Resident #23 was at risk for a mood problem due to her disease process and her diagnoses of depression and dementia with behavioral disturbance. Pertinent interventions included administering medications as ordered, providing behavioral health consults as needed, assisting the resident with identifying strengths and positive coping skills and providing the resident with a meaningful program of activities. The psychotropic medication care plan, revised 9/25/23, revealed Resident #23 was prescribed antidepressant and antipsychotic medications. Pertinent interventions included monitoring and recording occurrences of target behavior symptoms, including violence/aggression toward staff and others. A progress note, dated 4/29/24 at 2:42 p.m., revealed Resident #23 had a behavioral outburst on 4/27/24. Resident #23 had opened her roommate's closet and flung her clothes on the floor, told her roommate to get out and that it was her house, and blocked her roommate from coming inside. Resident #23's provider was notified and her condition was continuously monitored. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note, dated 4/29/24 at 8:35 p.m., revealed Resident #23 had agitated behavior and refused to take her evening medications. Emotional support was provided to Resident #23 to help her calm down and her practitioner was notified. A behavior note, dated 5/5/24 at 1:54 p.m., revealed Resident #23 showed aggressive behavior and had a verbal outburst toward her roommate and her roommate's representative. A provider note, dated 7/30/24 at 1:00 a.m. revealed Resident #23 was seen by the provider at the request of the nursing staff as they had observed increased aggressive behaviors in the evening. A behavior note, dated 10/2/24 at 9:26 p.m., revealed Resident #23 refused to go to bed. Resident #23 was cursing and screaming at staff and other residents and was kicking and grabbing at the staff. Resident #23 was offered a snack which she refused and threw at the staff. Staff tried to distract Resident #23 but she continued to yell. A provider note, dated 12/11/24 at 12:00 a.m., revealed Resident #23 was seen for a psychiatric follow-up. The provider met with Resident #23 and spoke with her representative to discuss discontinuing her quetiapine (antipsychotic medication) since Resident #23 had not had any new behaviors and was stable. The provider planned to decrease Resident #23's quetiapine to one tablet once a day for two weeks, then one half of a tablet for two weeks, then discontinue the medication. A provider note, dated 1/8/25 at 12:00 a.m., revealed Resident #23 was seen for a psychiatric follow-up. Resident #23's escitalopram (antidepressant medication) dose was decreased from 7.5 milligrams (mg) to 5 mg. Per the provider, Resident #23's representative did not notice any difference in the resident when they decreased her quetiapine dose and she wanted Resident #23 to be removed from any psychotropic medications. A behavior note, dated 2/4/25 at 1:01 p.m., revealed a staff member reported Resident #23 was yelling and cursing at another resident in the dining room around 12:30 p.m. The other resident was sitting next to Resident #23 and Resident #23 was saying do not look at me and started cursing and yelling. Resident #23 was distracted by the staff and became calm. The nurse practitioner was notified. D. Resident #77 (victim) 1. Resident status Resident #77, age 75, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia, anxiety and depression. The 12/2/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of ten out of 15. The resident was independent for all ADLs. The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Resident interview and observations (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 was interviewed on 2/4/25 at 3:22 p.m. Resident #77 said some people in the facility were bad and made her feel bad. Resident #77 said a person in the dining room made her feel bad, made her scared and hurt her feelings. Resident #77 said she could not go into the dining room. Resident #77 said the person gave her a hard time and told her to go back to her country. Resident #77 said people in the dining room saw it happen but did not say anything. On 2/4/25 at 4:09 p.m. Resident #77 was looking into the dining room and pacing, going in and out of the dining room. Resident #77 would peer into the dining room and then walk back out. She said someone gave her a hard time. Resident #23 was in the dining room with her representative at the time of the observation. E. Staff interviews The CC was interviewed on 2/5/25 at 10:11 a.m. The CC said the facility was investigating the incident from 2/3/25, reviewing footage and interviewing residents who were in the dining room. The CC said it seemed like Resident #23 was overstimulated and was saying things out loud but not directing them at anyone specifically. The CC said the facility was talking with Resident #23's representative about moving her to a lower-stimulus facility. RNA #1 was interviewed on 2/5/25 at 1:59 p.m. RNA #1 said most of the time, Resident #23 liked to get other residents' attention and fix whatever they were doing that she did not like. RNA #1 said the conflict on 2/3/25 started because Resident #23 told Resident #77 not to look at her. RNA #1 said Resident #23 was directing her words at Resident #77. RNA #1 said Resident #23 was using explicit language and asking Resident #77 why she was looking at her. RNA #1 said Resident #77 was saying she did not know why Resident #23 was saying that to her and why she was abusing her, and said she (Resident #77) did not do anything. RNA #1 said the incident on 2/3/25 was her first time seeing Resident #23 have an issue with another resident. She said Resident #23 had conflicts with staff and refused care. RNA #1 said the staff tried to calm Resident #23 down but the best thing was usually to leave her alone. RNA #1 said Resident #77 could also be trouble at times, but she had not had any conflict with any other residents or her caregivers. RNA #1 said the 2/3/25 incident was a big fight, but usually there were just smaller conflicts between residents. Certified nurse aide (CNA) #5 was interviewed on 2/5/25 at 2:21 p.m. CNA #5 said Resident #23 was fine if she was left alone but she would lash out when provoked. CNA #5 said she knew to redirect Resident #23 if she started talking about her daughter because that was when the resident started to become agitated. CNA #5 said if no one listened to Resident #23, she would put up a fight because Resident #23 knew what she wanted. CNA #5 said if she saw a resident-to-resident altercation she would separate the residents right away and tell the supervisor or administrator with no delay. The SSD and the social services consultant (SSC) were interviewed together on 2/5/25 at 2:55 p.m. The SSD said they were investigating a verbal altercation at the time of the interview that occurred between Resident #23 and Resident #77 on 2/3/25. The SSD said there were two residents in the dining room and, from what they could tell based on video footage and interviews, one resident started saying profanities. The SSD said Resident #23 was very particular about how she liked things. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility incident report, dated 3/4/24, was provided by the NHA on 2/6/25 at 2:48 p.m. The report revealed the following: Resident #69 chose to sit in the seat that Resident #235 typically sat in the dining room. When Resident #235 arrived to the dining room, she struck Resident #69 with an open hand on the head or neck. Staff intervened and separated the two residents immediately. Resident #69 was assessed by an RN and was unhurt and not upset or frightened. The facility notified the police and the ombudsman and initiated an investigation. The alleged assailant (Resident #235) was placed on increased monitoring and temporary one-on-one monitoring during mealtimes. Resident #235 had a history of being aggressive at home and had been observed to be physically and verbally aggressive towards other residents and staff members. The investigation documented Resident #235 had been involved in three other incidents in the 90 days prior to the incident. Resident #69 was interviewed but could not recall the event. Resident #235 was interviewed and said a lady was sitting in her spot and would not move. Resident #235 said she and the lady got into an argument and she moved. The facility did not substantiate the allegation of abuse. The facility determined the alleged assailant (Resident #235) did hit the alleged victim (Resident #69) with an open hand in the neck or head area, it was light and did not cause any bodily damage and did not cause the alleged victim pain or fear. The facility determined the incident did not rise to the level of abuse, per the abuse manual. -However, Resident #235 willfully hit Resident #69, when she was in her seat. B. Resident #235 (assailant) 1. Resident status Resident #235, age 85, was admitted on [DATE] and discharged to another facility on 4/4/24. According to the April 2024 CPO, diagnoses included Alzheimer's disease and a mood disorder with depressive features. The 4/4/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. The resident was independent for most ADLs. The MDS assessment documented the resident did not have physical or verbal behaviors directed at others. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior care plan, initiated 2/20/24, revealed Resident #235 had a history of being aggressive at home. Resident #235 had been observed to be physically and verbally aggressive toward other residents and staff members at the facility. Pertinent interventions included calling family members to spend time with Resident #235, finding a place for the resident to calm down, redirecting her away from staff members and residents, reviewing medications as needed and quarterly and engaging the resident in activities that interested her. The mood care plan, initiated 1/1/24, revealed Resident #235 had a mood disorder. Pertinent interventions included administering medications as ordered, arranging for a psychiatric consult and following up as needed and monitoring for any signs or symptoms of depression. A progress note, dated 1/22/24 at 12:20 p.m., revealed Resident #235 fought with another resident for a dining room seat. Resident #235 pushed the other resident. A social services staff member came to the dining room and tried to separate the residents but Resident #235 did not move. A progress note, dated 3/12/24 at 9:29 p.m., revealed Resident #235 was yelling at other residents in the hallway. Nursing staff attempted to separate Resident #235 from the other residents. C. Resident #69 (victim) 1. Resident status Resident #69, age greater than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included dementia and depression. The 1/9/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. The resident was dependent on staff for most ADLs. The MDS assessment documented Resident #69 did not have physical and behavioral symptoms directed toward others. D. Staff interviews CNA #5 was interviewed on 2/6/25 at 3:03 p.m. CNA #5 said Resident #69 did not have any issues with any other residents. CNA #5 said other residents would hold onto Resident #69 or follow her, but Resident #69 did not initiate contact with them. The NHA was interviewed on 2/6/25 at 6:48 p.m. The NHA said Resident #69 and Resident #235 got into a scuffle over seating in the dining room in March 2024. The NHA said he did not think Resident #235 was trying to hurt Resident #69, but she did hit her in the face. The NHA said Resident #235 had a history of resisting care. The NHA said there was a situation in the dining room in which two residents were trying to be friends with a third resident, so they were all trying to sit in one specific seat in the dining room. The NHA said the facility got rid of the seat in question and that eliminated the issue.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review, observations, and interviews, the facility failed to ensure residents unable to carry out activities of daily living (ADLs) received necessary services for three (#80, #1 and #53) of 10 residents reviewed for ADLs out of 47 sample residents. Specifically, the facility failed to: -Provide appropriate repositioning for eating and eating supervision for Resident #80; -Provide timely eating assistance for Resident #1; and, -Provide timely repositioning, bathing and oral care for Resident #53. Findings include: I. Facility policy and procedure The Activities of Daily Living, Supporting policy, revised March 2018, was received from the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: -hygiene (bathing, dressing, grooming, and oral care); -mobility (transfer and ambulation, including walking); -elimination (toileting); -dining (meals and snacks); and, -communication (speech, language, and any functional communication systems). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way, at a different time, or having another staff member speak with the resident may be appropriate. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.X. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #80 A. Resident status Resident #80, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing) and gastrostomy. The 1/16/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent with toileting and transfers, required substantial/maximal assistance with personal hygiene, bed mobility and supervision with eating. B. Observations and resident interview Resident #80 was interviewed in the presence of two family members on 2/3/25 at 10:14 a.m. Resident #80 said she had been given her medications crushed in yogurt. She said when the nurse left, she started choking on the medications and vomited. Resident #80's family members verified the choking/vomiting incident had occurred. During the interview, there was a sign observed above Resident #80's bed for meals and food to be in small bites and no straws in drinks. On 2/4/25 at 9:05 a.m. Resident #80 was lying in bed with her breakfast tray sitting on her overbed table. The head of the resident's bed was not positioned in an upright position and she was not attempting to feed herself. There were no staff members in the room offering or assisting the resident with her meal. During a continuous observation on 2/5/25, beginning at 8:45 a.m. and ending at 10:00 a.m., the following was observed: At 8:45 a.m. Resident #80 was lying in bed and the head of her bed was not positioned in an upright position. The resident's breakfast tray was on her overbed table with the lid removed. Resident #80 was not attempting to feed herself. There were no staff members in the room offering or providing cueing or eating assistance to the resident. At 10:00 a.m. an unidentified staff member entered the resident's room and removed her breakfast meal tray. The unidentified staff member did not offer or provide cueing or eating assistance to Resident #80 prior to removing the meal tray from the resident's room. During a continuous observation on 2/5/25, beginning at 12:45 p.m. and ending at 1:50 p.m., the following was observed: At 12:45 p.m. an unidentified staff member delivered a lunch meal tray to Resident #80 and left the room. Resident #80 was lying on her back and the head of her bed was not positioned in an upright position. The resident's lunch meal tray was not set up for her prior to the unidentified staff member leaving the resident's room. There were no other staff members who entered the resident's room to offer or provide cueing or eating assistance to the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:50 p.m. registered nurse (RN) #1 entered Resident #80's room and asked the resident if she was done with her lunch meal tray before exiting the room RN #1 did not offer or provide cueing or eating assistance to the resident prior to leaving the room. At 2:45 p.m. Resident #80 was calling out and RN #1 entered the room a second time to check on the resident. RN #1 proceeded to remove the resident's lunch meal tray from the resident's room without offering or providing cueing or eating assistance to the resident. C. Record review The nutrition care plan, initiated 1/22/25, documented Resident #80 was at risk for nutritional problems related to diabetes mellitus, cerebral edema, hypertension and gastroesophageal reflux disease (GERD). Interventions included monitoring the resident's weights, monitoring/documenting/reporting signs of dysphagia (pocketing, choking, coughing, drooling, holding food in mouth, multiple attempts at swallowing, refusing to eat), providing diet as ordered, monitoring intake, reporting signs of malnutrition and the registered dietitian (RD) was to evaluate. -The care plan failed to reveal Resident #80 required supervision or assistance with eating and had swallowing precautions due to her dysphagia diagnosis. A comprehensive review of Resident #80's meal assistance documentation from 1/9/25 to 2/4/25 revealed inconsistent eating assistance was provided for the resident. The meal assistance documentation revealed the resident was documented as independent with eating 22 times, required set up 25 times, required partial/moderate assistance three times and required substantial/maximal assistance one time. D. Staff interviews RN #1 was interviewed on 2/6/25 at 7:55 a.m. RN #1 said Resident #80 could feed herself and did not require assistance with eating. She said staff needed to watch her while she ate and staff would periodically go into her room and check on her. The DON was interviewed on 2/6/25 at 3:26 p.m. The DON said Resident #80 had been at the facility for less than a month. She said Resident #80 had a traumatic brain injury and a craniotomy while at the hospital. She said Resident #80 had a speech evaluation for swallowing at the facility and had passed. She said the resident required a mechanically soft diet and could take her medications in pudding. She said anyone on a therapeutic diet had a potential for aspiration or choking and should have their head positioned in an upright position during meals. The DON said she did not know the level of assistance Resident #80 required for eating. She said residents that required supervision should have staff supervision during meals. She said therapeutic diets, diet restrictions and precautions should be care planned and communicated to nursing staff. 51163 III. Resident #1 A. Resident status (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 2/6/25, beginning at 12:28 p.m. and ending at 1:09 p.m., the following was observed: At 12:28 p.m. Resident #1's meal tray was delivered. The tray was not placed within her reach. At 1:09 p.m. (37 minutes after the meal tray was delivered) an unidentified nursing student went in to assist Resident #1 with her meal. C. Record review The nutrition care plan, revised on 1/24/25, revealed that Resident #1 had a nutritional problem due to difficulty with self-feeding which was related to physiological causes, dementia and brain damage. Interventions included assisting the resident one-on-one at meals and monitoring for signs and symptoms of dysphagia. The ADL care plan, initiated 8/16/23, revealed that Resident #1 had a self-care deficit related to her dementia and brain damage. The resident needed assistance with eating her meals. D. Staff interviews CNA #9 was interviewed on 2/6/25 at 2:00 p.m. CNA #9 said Resident #1 could only feed herself when it was finger foods. He said when she tried to use utensils to eat her meals, she spilled all over herself. He said he did not see any difference between the resident's food being left on her bedside table or being left in the meal delivery cart until someone can assist her because the resident's food would get cold either way. The nursing home administrator (NHA) was interviewed on 2/6/25 at 7:10 p.m. The NHA said it was inappropriate to have leave Resident #1's room tray sitting out of reach in front of her until someone could assist her with eating. 51915 V. Resident #53 A. Resident status Resident #53, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included central pontine myelinolysis, chronic pulmonary obstructive disease with exacerbations, chronic respiratory failure with hypoxia, dysphagia, aphasia, and quadriplegia. The resident could not communicate, was dependent on supplemental oxygen, and had a tracheostomy and a gastrostomy. The 1/23/25 MDS assessment revealed that a BIMS score assessment was not conducted. The resident had severely impaired cognitive skills for daily decision making and long term and short term memory problems, based on staff assessment. Resident #53 was dependent and required the assistance of two or more staff members for bed mobility, dressing, toileting, personal hygiene and bathing. B. Observations (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/25 at 11:43 a.m. Resident #53 had white residual in her mouth, around her lips and between her teeth. The resident had a body odor and her face was oily. On 2/4/25 at 2:30 p.m. Resident #53 had a strong body odor. On 2/5/25 at 9:15 a.m. Resident #53 had white residual in her mouth and between her teeth. During a continuous observation on 2/5/25, beginning at 1:00 p.m. and ending at 5:00 p.m., the following was observed: At 3:29 p.m. RN#4 entered Resident #53's room and performed aspiration (removal) of secretions from the resident's tracheostomy. While RN #4 was in the room, checked the resident's brief for incontinence and noted the resident was dry. However, RN #4 did not reposition Resident #53 while he was in the room. -The facility failed to reposition Resident #53 during the four hour continuous observation. C. Record review The 1/21/25 ADLs care plan revealed Resident #53 was totally dependent on two staff members to provide baths and showers as necessary. The care plan indicated the resident was to be turned and repositioned frequently to decrease pressure. The care plan further indicated staff was to provide the resident with mouth care as per ADL personal hygiene and apply lip balm/ointment to the resident's lips as needed. A review of Resident #53's electronic medical record (EMR) revealed that the resident received only one bath per week. Resident #53 had her last two baths on 1/31/25 and 1/24/25. D. Staff interviews CNA #8 was interviewed on 2/6/25 at 3:26 p.m. CNA #8 said he checked Resident #53 every two hours for incontinence care, repositioned her every two hours and cleaned her mouth two to three times a day, and as needed. He said all CNAs should do the same. CNA #8 said Resident #53 needed two people for assistance. RN #4 was interviewed on 2/5/25 at 5:20 p.m. RN #4 said the CNAs checked Resident #53 every two hours because she could not move or communicate and staff should assist her with repositioning, toileting, mouth care and grooming. The DON was interviewed on 2/6/25 at 7:21 p.m. The DON said the staff should reposition Resident #53 and wash her face and mouth every few hours. The DON was unaware that Resident #53 had not received a bath in six days.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure two (#184 and #75) of seven residents reviewed for pressure ulcers out of 47 sample residents received the necessary treatment and services according to professional standards of practice to prevent or heal pressure injuries. Specifically, the facility failed to: -Provide dressing changes for consecutive days for Resident #184, who was admitted to the facility with an unstageable pressure wound to his coccyx; -Ensure Resident #184's care plan was updated in a timely manner; and, -Provide timely wound prevention interventions and ensure interventions were consistently implemented for Resident #75, who was admitted to the facility with pressure ulcers to his coccyx and both heels. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from https://www.internationalguideline.com/guideline on 2/10/25, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Injury policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 2/10/25 at 11:56 a.m. It read in pertinent part, Conduct a thorough skin assessment. The facility will complete this assessment upon admission and weekly thereafter unless otherwise indicated. It is important that each existing pressure injury be identified, whether present on admission or developed after admission, and that factors that influenced its development, potential for development of additional pressure injuries, or for the deterioration of the pressure injuries be recognized, assessed or addressed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive assessment of a pressure injury will be performed by the wound nurse or designee to include the following: differentiate the type of injury (pressure versus non pressure related), determine the stage of the pressure injury, measure the pressure ulcer (length by width by depth), description of exudate, description of wound, description of surrounding skin, presence of tunneling/sinus tract formation, determine if infection is present, monitor the progress toward healing and for potential complication, assess, treat, and monitor pain and monitor the efficacy of dressings and treatments. III. Resident #184 A. Resident status Resident #184, age 70, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included right lower extremity cellulitis with skin transplant on open wound right lower leg, malnutrition and unstageable ulcer of sacral region. According to the 1/29/25 nursing admission assessment, Resident #184 was alert and oriented to person, time, place and situation. He was independent with eating, required assistance with bed mobility, personal hygiene and transfers and was dependent with toileting. B. Resident interview and observation Resident #184 was interviewed on 2/3/25 at 10:06 a.m. Resident #184 said he had a pressure wound on his tail bone and that was why he had an air mattress. During the interview, Resident #184 was observed to be on an air mattress with heel boots in place. C. Wound care observations On 2/6/25 at 10:00 a.m. the wound care physician (WCP) removed a bordered gauze dressing covering Resident #184's sacral wound. The sacral wound bed (the surface area of a wound, encompassing the tissue within the wound itself) appeared dark red in color. There was no slough (dead yellow or white tissue present on the wound bed) or eschar (necrotic or dead tissue covering a wound bed, typically dry, black and firm) noted in the wound bed. According to the WCP, measurements of the coccyx wound were 2.2 centimeters (cm) by 2.1 cm by 0.7 cm, with undermining (when the edges of the wound separate from the surrounding healthy tissue, creating a cavity or pocket beneath the skin) present from the 9:00 position to the 2:00 position and a maximum measurement for undermining of 1.5 cm at the 12:00 position. D. Record review The skin integrity care plan, initiated 2/4/25, indicated Resident #184 had a coccyx pressure injury. Interventions included administering treatments and monitoring effectiveness, assessing and monitoring wound healing weekly, assisting the resident to shift weight and pressure relieving devices in wheelchair, encouraging repositioning throughout shifts and assisting as needed, utilizing pressure relieving devices, enhanced barrier precautions, floating heels, assessing and monitoring by the wound care physician and using a pressure relieving mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the comprehensive skin care plan was not initiated until 2/4/25, seven days after Resident #184 was admitted to the facility with a pressure wound to his coccyx (tail bone). The 1/28/25 nursing progress note documented a pressure wound on Resident #184's tail bone. The nurse practitioner was notified and an air mattress was initiated. -Review of Resident #184's January 2025 CPO revealed there was no physician ordered treatment for the resident's coccyx wound. Resident #184's 1/29/25 nursing admission assessment documented the resident had a coccyx wound with an intact dressing. -However, there were no physician's orders for dressing changes of the coccyx wound (see January 2025 CPO above). The 1/31/25 nursing progress note documented a coccyx wound with an intact dressing. -However, there was no physician's order for dressing changes of the coccyx wound (see January 2025 CPO above). -A review of Resident #184's January 2025 treatment administration record (TAR) failed to reveal wound care orders for the treatment of the coccyx wound or documentation to indicate the resident had been provided with wound dressing changes to his coccyx wound. Review of Resident #184's February 2025 CPO revealed the resident had the following physician's order for wound care: Cleanse the coccyx with wound cleanser, pat dry, apply skin prep, calcium alginate and a bordered gauze dressing. Change dressing every other day and as necessary, ordered 2/2/25. -The physician's order for treatment of Resident #184's coccyx pressure wound was not obtained until five days after the resident's admission to the facility. A review of Resident #184's February 2025 TAR revealed the resident's coccyx wound dressing was not documented as being changed on 2/2/25 or 2/3/25, after the physician's order was obtained on 2/2/25 (see physician's order above). The February 2025 TAR documented a dressing change for the resident's coccyx wound on 2/4/25. -Resident #184's dressing was not documented as being changed until seven days after the resident was admitted to the facility. E. Staff interviews (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The WCP was interviewed on 2/6/25 at 10:20 a.m. The WCP said the facility would notify him what wounds he needed to see for residents. He said he had seen Resident #184 for the first time the week prior for care of his right lower leg wounds. He said early and accurate identification of pressure wounds was important to be able to place interventions timely, which included dressing changes, pressure relieving devices and frequent repositioning to help prevent deterioration. He said the unstageable coccyx wound was now open which was good because now it could heal. Registered nurse (RN) #1 was interviewed on 2/6/25 at 2:45 p.m. RN #1 said a head to toe skin assessment was completed on all residents and was documented on the admission nursing assessment. She said any wounds identified were reported to the director of nursing (DON) so that the resident could be referred to the WCP. Certified nurse aide (CNA) #1 was interviewed on 2/6/25 at 2:55 p.m. CNA #1 said Resident #184 had a wound and should be offered frequent repositioning. He said if he identified a new wound while providing resident care or a resident's wound looked worse or smelled, he would notify the nurse taking care of the resident. The DON was interviewed on 2/6/25 at 4:54 p.m. The DON said when residents were admitted to the facility, she and the minimum data set (MDS) coordinator would review the admission referral and identify which residents had existing pressure wounds upon admission. She said she would take a picture of the residents' wounds and send it to the WCP to get guidance on how to proceed with treatment of the wound. The DON said Resident #184 had been admitted to the facility with a coccyx wound. She said she reviewed the hospital's referral for the resident, during the survey, and the wound note documentation said the resident's wound was an unstageable pressure wound. She said Resident #184 was placed on an air mattress after admission as a preventative measure for his coccyx wound. She said it was important that treatment interventions, such as dressing changes be completed timely to help prevent further deterioration of the wound. She said further education was required for staff to make sure that interventions were care planned and dressing changes were initiated timely. 51710 IV. Resident #75 A. Resident status Resident #75, age 82, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included displaced fracture of the left hip, difficulty swallowing, generalized muscle weakness, history of falling and limitation of activities due to disability. The 1/9/25 MDS assessment revealed the resident had mild cognitive impairment with a BIMS score of 11 out of 15. He required setup assistance with eating and oral/personal hygiene. He required moderate assistance with bed mobility and transfers. He was dependent on staff for toileting hygiene and dressing. He was frequently incontinent of bowel and bladder. It documented Resident #75 was admitted with two Stage 2 pressure injuries. It documented interventions in place: a pressure-reducing device for a chair, pressure-reducing device for his bed, pressure injury care, and application of dressings to Resident #75's feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, Resident #75 was not observed utilizing a pressure-relieving mattress upon observation (see below). The assessment indicated he did not have behaviors. B. Resident interview Resident #75 was interviewed on 2/6/25 at 8:58 a.m. Resident #75 said he had pain in both of his heels and floating his heels on a pillow helped alleviate some of the pain. He said his coccyx hurt as well, however, it was painful for him to lay on his left and right sides. He said he had difficulty repositioning himself onto his sides from his back and said staff did not often reposition him. He said he had not been feeling well the past few days and wanted to stay in bed. C. Observations On 2/3/25 at 11:55 a.m. Resident #75 was lying on his back in bed. He had a wrapped dressing on his left heel and his right heel was open to air. His left heel was floated (offloaded) on a pillow, however, his right heel was not on the pillow and was resting directly on the bed. There was no alternative pressure mattress on his bed. On 2/4/25 at 10:47 a.m. Resident #75 was sleeping in his bed. He was lying on his back and both heels were floated on a pillow. However, the bottoms of both of his feet were touching the footboard. On 2/4/25 at 3:23 p.m. Resident #75 received incontinence care from CNA #2. Resident #75 required maximum assistance from CNA #2 to reposition from his back to his left and right sides. He was visibly incontinent of stool and urine, and there was stool visible on his gown and bed sheets. His coccyx and groin were red with approximately four to eight dark spots towards the edge of the redness. There was no dressing on Resident #75's coccyx and his skin was slightly covered with a previously applied barrier cream. He had a wrapped dressing on his left heel, which was dated 2/4/25. His right heel was red and was open to air with a non-skid sock covering the rest of his foot. After completing incontinence care, Resident #75 was repositioned onto his left side by CNA #2 and his heels were floated on a pillow. A pillow was not placed in between his knees to help offload pressure. On 2/5/25 at 1:22 p.m. Resident #75 was lying on his back in bed asleep. His heels were floated on a pillow, however, the bottoms of his feet were touching the footboard. There was not an alternative pressure mattress on the resident's bed. On 2/5/25 at 4:48 p.m. Resident #75 received incontinence care from CNA #1. Resident #75 required maximum assistance from CNA #1 to reposition from his back onto his left and right sides. There was no dressing on the resident's coccyx, and it was red with approximately four to eight dark spots towards the edge of the redness. Resident #75's coccyx was slightly covered with a previously applied barrier cream. He was incontinent of urine. He had a gauze-wrapped dressing to his left heel, dated 2/4/25. His right heel was red and open to air. On 2/6/25 at 11:40 a.m. Resident #75 was seen for a visit by the facility's WCP. The DON was present to assist during the visit. The DON told the WCP that Resident #75 was being seen as a follow-up for an existing pressure injury on his left heel, however, she did not mention the resident's right heel or coccyx. Upon repositioning Resident #75 to his left side for wound care, the WCP and the DON observed the redness to the resident's coccyx, which was not covered with a dressing, and the resident's right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin care plan, initiated 2/3/25 (during the survey), revealed Resident #75 was receiving treatment for a stage two pressure injury to his right heel, a stage three pressure injury to his left heel and a dehisced (separation of the edges of a previously closed wound) abdominal wound. Pertinent interventions included administering treatments as ordered and monitoring for effectiveness, an alternating pressure mattress to bed set to medium/alternating firmness, encouraging Resident #75 to reposition himself throughout the shift and assisting as needed, floating heels while in bed, using barrier cream after incontinent episodes, as indicated and weekly nursing skin checks. -However, the skin care plan was not initiated until one month after Resident #75 was admitted to the facility (1/2/25) with wounds. -Additionally, the care plan failed to include the wound to Resident #75's coccyx (see observations above). A general record note, dated 1/2/25 at 12:43 p.m., documented Resident #75 was admitted to the facility at 12:25 p.m. The note documented Resident #75 had open wounds to both of his heels and an open area and redness on his coccyx. A weekly nursing documentation assessment, dated 1/21/25 at 9:40 p.m., documented Resident #75 utilized a wheelchair cushion. The note documented he had a rash/redness to his coccyx that was being treated and a right heel wound that was healing well with betadine. The note documented a left heel wound that was noted upon admission and was being treated. It documented Resident #75 had existing bruises and rashes on his skin. A WCP visit note, dated 1/23/25, documented Resident #75 was evaluated for pressure injuries to both the right and left heels, a neuropathic (nerve damage) wound on his left heel and a dehisced abdominal wound. The note documented Resident #75's left heel wound was worsening and should be listed as unavoidable. His right heel was not healed, however, it was improving. The note documented a debridement (tissue removal) procedure on Resident #75's left heel wound was performed. The note additionally documented orders for pressure injury interventions included turning and repositioning the resident frequently while in bed or chair, placing Resident #75 on a low air loss or alternative pressure mattress, floating his heels while in bed and checking incontinence briefs frequently. -However, observations during the survey revealed several occasions when the resident's heels were not floated or were in contact with the bed's footboard, and there was no alternative pressure mattress on the resident's bed (see observations above). -Additionally, the physician's order for an alternative pressure mattress was not obtained until 2/4/25, during the survey (see physician's orders above). A weekly nursing documentation assessment, dated 1/29/25 at 2:06 p.m., documented Resident #75's skin was intact and he had no new skin concerns. The note documented Resident #75 was not using any specialized equipment, such as a specialty bed or wheelchair cushion. -However, the WCP visit note on 1/23/25 documented the presence of several wounds on the resident's skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weekly wound note, dated 1/30/25 at 8:26 a.m., documented Resident #75's left heel pressure injury had a date of onset 1/2/25, was a stage three wound and was worsening. The note documented the wound was being treated with silver alginate. A nurse progress note, dated 2/3/25 at 11:33 p.m., documented Resident #75 was noncompliant with care. The note documented the resident would have a bowel movement and sit in it, refusing to allow staff to assist in cleaning him up. The note documented the nurse explained to Resident #75 that his care refusals could lead to skin breakdown, however, Resident #75 stated he did not care. E. Staff interviews The WCP and the DON were interviewed together on 2/6/25 at 12:12 p.m. The WCP and the DON said they were not aware of the wounds on Resident #75's right heel and coccyx. The DON said Resident #75 had a previous wound on his right heel, however, it had improved and was resolved on 1/30/25. She said she was not aware the wound had reopened. The WCP said Resident #75's left heel wound was stage four pressure injury, his right heel wound was a deep tissue injury over scar tissue and the coccyx wound was a stage two pressure injury. The WCP and the DON said Resident #75 was not currently using an alternative pressure mattress and the resident needed one to assist with wound healing. CNA #3 was interviewed on 2/6/25 at 2:40 p.m. CNA #3 said Resident #75 was total care and dependent on staff for assistance with ADLs. She said the resident was incontinent. CNA #3 said dependent residents should be repositioned every two hours. She said skin protectant creams were supposed to be used every time peri-care was completed and any new skin issues should be reported to the nurse. CNA #1 was interviewed on 2/6/25 at 3:07 p.m. CNA #1 said Resident #75 was dependent on staff for incontinence care, showering and repositioning. She said residents should be repositioned every two hours, however, some residents may have different care plans. She said newly identified skin issues should be reported to the nurse. She said she had previously seen wound dressings on Resident #75's coccyx, however, she said he no longer needed them because his wound had improved. CNA #1 said barrier cream was applied after incontinent episodes to prevent skin breakdown. She said the resident's nurse should be notified if a dressing came off or became dislodged. RN #3 was interviewed on 2/6/25 at 3:16 p.m. RN #3 said dependent residents should be repositioned every two hours to prevent skin breakdown. She said Resident #75 was admitted to the facility with a stage two pressure wound on his coccyx, a widespread rash and stage two pressure wounds on both heels. She said there was an order to put zinc cream onto his coccyx for wound prevention, however, she said there was not an order to apply Mepilex to Resident #75's coccyx. After RN #3 reviewed Resident #75's February 2025 CPO for his coccyx wound orders, she said there was an order for Mepilex dressings, however, she said she had not been applying them because they would not adhere to Resident #75's skin due to the topical zinc cream applied to the wound. She said she would coat on a lot of zinc to treat the wound and told the CNAs to use a lot of barrier cream with incontinence care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed a second time on 2/6/25 at 4:03 p.m. The DON said residents at high risk for skin breakdown and who were dependent on staff for ADL care should be repositioned at least every two hours. She said if a change in condition was noted, it should be reported to the resident's nurse or the DON. She said when Resident #75 was admitted , he had redness on his coccyx, however, she said it resolved with the use of barrier cream. The DON said she was not informed Resident #75 had new redness and an open wound on his coccyx. She said she asked RN #3 about his wound and RN #3 told her Resident #75's coccyx appeared red and shiny on 2/5/25, however, no open wounds were observed. The DON said RN #3 was not following physician's orders by not applying a Mepilex dressing to Resident #75's coccyx wound. She said she would follow up with RN #3. She said Resident #75's bed mattress was being switched to an alternative pressure mattress (on 2/6/25).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for four (#26, #31, #15 and #54) of nine residents reviewed for accident hazards out of 47 sample residents. Specifically, the facility failed to: -Ensure person-centered interventions were in place to prevent elopement incidents for Resident #26 and Resident #31; -Ensure staff provided appropriate supervision and implemented care-planned interventions for Resident #15 while smoking; and, -Ensure care-planned interventions for falls were consistently implemented for Resident #54. Findings include: I. Failed to ensure person-centered interventions were in place to prevent elopement incidents for Resident #26 and Resident #31 A. Facility policy and procedure The Elopement & Wandering policy and procedure, dated 2/29/24, was provided by the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, It is a goal of the facility to provide a safe environment using the least restrictive measures available in caring for residents who are exhibiting elopement behavior. If the resident is identified as an elopement risk, the following will be maintained: implementing and care planning interventions to address safety and decrease the risk of elopement, the care plan will be updated to include that an electronic alarm system is used for the resident's safety. B. Resident #26 1. Resident status Resident #26, age 76, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included vascular dementia, adjustment disorder with mixed anxiety and depression and repeated falls. The 1/9/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) assessment score of three (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of 15. The resident was dependent on staff for dressing, bathing and toileting and required setup to moderate assistance for all other activities of daily living (ADL). The assessment documented the resident did not have a wander/elopement alarm and did not exhibit wandering behavior. 2. Facility incident report The facility incident report, dated 9/14/24 at 5:40 p.m., was received from the nursing home administrator (NHA) on 2/6/25 at 1:31 p.m. The report revealed Resident #26 was last seen at 5:40 p.m. on 9/14/24. Review of camera footage revealed Resident #26 had followed a visitor out of the facility doors. The facility staff searched the building, neighborhood and nearby stores but could not find Resident #26. At 10:00 p.m. that night (9/14/24), Resident #26 was found wandering approximately one and a half miles away from the facility. Paramedics were called and Resident #26 was found to be in good health and returned to the facility. The building's wander alarm system was assessed and found to be in good working condition. Resident #26 still had her wander alarm on when she returned to the facility and the administrators verified it was working correctly. Resident #26 was temporarily placed on increased monitoring. 3. Record review The elopement care plan, initiated 7/31/24 and revised 10/31/24, revealed Resident #26 was an elopement risk due to her diagnosis of dementia. Pertinent interventions, initiated on 7/31/24, included assessing Resident #26 for fall risk and providing the resident with structured activities including toileting, walking inside and outside and reorientation strategies. Additional interventions, initiated on 9/18/24, included checking Resident #26 to ensure her wander alarm was in place and to redirect the resident when she was going toward the facility doors to exit-seek. -Resident #26's care plan was not updated following a second incident where she was found outside the facility on 10/1/24 (see progress note below). A wander/elopement evaluation, dated 7/31/24, revealed Resident #26 was an elopement risk and would be observed by staff closely. A wander/elopement evaluation, dated 10/31/24, revealed Resident #26 was a high elopement risk. Review of Resident #26's February 2025 CPO revealed the following physician's orders: -Apply wander alarm to prevent resident from going out of the facility unassisted. Monitor presence of wander alarm every shift, ordered 7/31/24; and, -Behavior monitoring for antidepressant medication: document number of episodes of target behavior and document in progress notes every eight hours as needed, ordered 7/31/24. A progress note, dated 7/31/24 at 4:00 p.m., revealed a nurse found Resident #26 trying to go out the front doors of the facility by herself. The nurse notified Resident #26's provider and received an order to apply a wander alarm to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 7/31/24 at 9:20 p.m., revealed Resident #26 attempted to go out of the facility three times but was redirected away from the doors. A provider note, dated 8/9/24 at 1:00 a.m., revealed Resident #26 was seen by the nurses station pacing back and forth wanting to find out if she could go home. A progress note, dated 9/2/24 at 12:52 p.m., revealed Resident #26 had a wander alarm applied to her leg since admission which still functioned well. The nurse reminded Resident #26 that she was not to leave the facility without facility support because of her memory problem and Resident #26 verbalized understanding. Resident #26 was kept on continuous monitoring. A progress note, dated 9/2/24 at 9:11 p.m., revealed at 3:00 p.m. that afternoon (9/2/24) Resident #26 had packed all of her belongings and brought them to the facility entrance to go home. The nurse explained to Resident #26 that the facility was her home but the resident did not listen to her and was agitated for the next hour. The nurse gave Resident #26 emotional support and explained her situation again and again, and the resident calmed down around 5:00 p.m. that evening (9/2/24). Resident #26's wander alarm was in place and the resident was kept on continuous monitoring. A progress note, dated 9/14/24 at 6:35 p.m., revealed the administration was alerted at approximately 5:30 p. m. that Resident #26 was missing from the facility. Staff searched the building and were unable to locate the resident. A nurse said she saw Resident #26 at approximately 5:00 p.m. that evening (9/14/24) and confirmed the resident wore a wander alarm that was working appropriately. Resident #26 had not signed out at the front desk and her emergency contacts had not seen her. The police and the facility's administrators were notified, and the department heads of the facility drove around the community but were unable to locate the resident. A progress note, dated 9/14/24 at 11:15 p.m., revealed Resident #26 was returned to the facility. Resident #26 did not have any complaints of pain or discomfort and her vital signs were within normal limits. A progress note, dated 9/14/24 at 11:31 p.m., revealed Resident #26 was returned to the facility by the NHA. Resident #26 was escorted back to her room by a nurse. A progress note, dated 9/15/24 at 11:56 a.m., revealed Resident #26 was alert and able to make needs known verbally. Resident #26 was reminded not to leave the facility without support. Resident #26 walked the hallways of the facility and in the courtyard several times and was monitored continuously. A progress note, dated 9/29/24 at 10:50 a.m., revealed Resident #26 was seen walking around and checking to see if the doors to the facility were unlocked. Resident #26 was observed trying to get out of the facility with two other residents. Resident #26 was redirected to attend bingo in the dining room. Resident #26 got upset and made a fist at the nurse as she was walking into the dining room. A progress note, dated 10/1/24 at 5:50 p.m., revealed Resident #26 was found outside the facility. Resident #26 was brought back into the facility, and the nurse heard the wander alarm sounding. Resident #26 said she knew she needed to stay inside but when she pushed the door it opened and she went through it. Resident #26 was reminded that she needed to stay inside the building because of her forgetfulness. Resident #26's location was monitored with frequent rounding by the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behavior monitoring records, from 7/31/24 through 2/6/25, revealed Resident #26's behaviors were monitored and recorded at least once each day since admission. In each instance of behavior documentation, it was documented that the behavior tracking was not applicable or that Resident #26 did not have any behaviors during that time. The behavior tracking monitored several behaviors, including wandering and exit-seeking. -However, progress notes from 7/31/24 through 10/1/24 revealed Resident #26 exhibited exit-seeking and wandering behaviors on several occasions (see above). 4. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 2/6/25 at 2:59 p.m. CNA #5 said the facility used wander alarms for residents who wandered around the building. CNA #5 said the alarm went off if the resident tried to exit the building and the staff had to go check the door if they heard the alarm going off. CNA #5 said Resident #26 was always walking around the facility but never tried to exit the building. -However, according to progress notes, Resident #26 was found outside the facility on 9/14/24 and 10/1/24 (see record review above). Registered nurse (RN) #1 was interviewed on 2/6/25 at 3:19 p.m. RN #1 said Resident #26 walked around the facility a lot but did not try to leave. RN #1 said Resident #26 would get confused and say she wanted to go home but the resident never went outside. -However, according to progress notes, Resident #26 was found outside the facility on 9/14/24 and 10/1/24 (see record review above). Receptionist (RECP) #1 was interviewed on 2/6/25 at 4:29 p.m. RECP #1 verified Resident #26's information was in the facility's elopement binder kept at the front desk. RECP #1 said Resident #26 did not try to get out of the facility. RECP #1 said Resident #26 was able to get a few feet out of the facility one time over the previous summer but was redirected back into the building. RECP #1 said the only times Resident #26 had gotten close enough to the facility doors to set off the wander alarm was when she went out for appointments. -However, according to progress notes, Resident #26 was found outside the facility on 9/14/24 and 10/1/24 (see record review above). The director of nursing (DON) was interviewed on 2/6/25 at 7:34 p.m. The DON said Resident #26 was declining. The DON said Resident #26 had been eloping from the facility previously and had gotten all the way to another area of the city from the facility. The DON said when Resident #26 first came to the facility, her previous apartment was just behind a nearby store, so the resident was familiar with the area. The DON said Resident #26 would stand in the facility lobby and talk about her previous apartment. The DON said Resident #26 would go to the doors every time the facility staff turned around. The DON said Resident #26 was very smart about her elopement attempts and would wait for groups of visitors to go in and out of the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said one night (9/14/24), Resident #26 walked out of the building with another family who let her out. The DON said the facility immediately went out to look for her and the NHA eventually found her. The DON said Resident #26 stopped wandering after the 9/14/24 incident. The DON said Resident #26 had her wander alarm in place during the incident and she had tried lots of ways to get her wander alarm off. The DON said the interventions used for Resident #26 prior to the 9/14/24 incident included having her room across from the nurse's station and trying to distract Resident #26. The DON said the nursing staff would also walk with Resident #26 around the facility. -However, according to progress notes, Resident #26 was found outside the facility a second time on 10/1/24 (see record review above). C. Resident #31 1. Resident status Resident #31, age less than 65, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included alcohol dependence with alcohol-induced amnesic disorder (short-term memory loss associated with chronic alcohol use), dementia with agitation and a history of falling. The 12/11/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 12 out of 15. The resident was independent or required supervision for all ADLs. The MDS assessment documented the resident did not exhibit wandering behaviors. The assessment documented a wander/elopement alarm was used daily. 2. Observations On 2/4/25 at 9:55 a.m. Resident #31 was redirected from the facility exit by an unidentified staff member. The staff member told Resident #31 not to go out the front door and if Resident #31 wanted to smoke, she needed to go to the smoking area doors. At 3:16 p.m. Resident #31 was seen pacing around the facility and going in and out of her room. On 2/5/25 at 8:59 a.m. Resident #31 was pacing through the facility hallways near the dining room. At 4:36 p.m. Resident #31 was pacing the hallways and asking for a cigarette. On 2/6/25 at 8:38 a.m. Resident #31 entered her room and promptly left her room before returning to pacing around the facility. 3. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The elopement care plan, initiated 9/15/17, revealed Resident #31 was at risk for elopement related to her intermittent confusion. Resident #31 had poor impulse control and at times would ask to leave the facility to move in with her sister and mother. Pertinent interventions, initiated on 9/15/17, included offering emotional and psychological support as needed, checking the placement and function of Resident #31's wander alarm and orienting the resident to her environment as needed. Additional interventions, initiated on 6/14/18, included having a wander alarm in place. A second elopement care plan, initiated 7/10/23, revealed Resident #31 was an elopement risk. Pertinent interventions included distracting Resident #31 from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. A progress note, dated 11/10/24 at 3:41 p.m., revealed Resident #31 was able to get out of the front door and into the parking lot. Resident #31 was redirected back into the facility and her wander alarm was in place and functional. The DON was notified. A psychiatric medication review note, dated 1/8/25 at 11:30 a.m., revealed Resident #31 displayed ongoing impulsivity and exit-seeking behaviors. Resident #31's dose of sertraline (an anxiety medication) was increased from 50 milligrams (mg) to 100 mg to manage her anxiety. A progress note, dated 1/19/25 at 1:52 p.m., revealed Resident #31 was seen outside of the facility on the street by another resident through her room's window at 11:15 a.m. that morning. Staff redirected Resident #31 back into the facility, assisted her to her room and encouraged her to lay in her bed. The DON and Resident #31's provider were notified. A discharge planning note, dated 1/21/25 at 1:50 p.m., revealed the social services director (SSD) spoke with Resident #31's representative to discuss Resident #31 needing a higher level of care due to her increased confusion and elopement attempts. Resident #31's provider recommended placing her in a secured unit. A referral to another facility was sent out and accepted but no discharge date was scheduled. 4. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/6/25 at 10:22 a.m. LPN #1 said Resident #31 got agitated and started walking around and tried to leave the facility. LPN #1 said Resident #31 tried to leave the facility to get cigarettes. LPN #1 said Resident #31 had a wander alarm but sometimes visitors held the door open for her because they thought she was a visitor. LPN #1 said the facility had to educate visitors to not let people out of the building. LPN #1 said Resident #31 had not made it out of the facility to her knowledge and was easily redirected back to her room or to an activity. -However, according to progress notes, Resident #31 was found outside the facility on 11/10/24 and 1/19/25 (see record review above). RECP #1 was interviewed on 2/6/25 at 4:29 p.m. RECP #1 verified Resident #31's information was in the elopement binder at the front desk. RECP #1 said Resident #31 was always trying to go out of the facility to get cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 2/6/25 at 7:56 p.m. The DON said Resident #31 always wanted cigarettes. The DON said Resident #31 was exit-seeking but did not go out of the facility. The DON said Resident #31 had a wander alarm in place. The DON said the administration was looking for a different facility for Resident #31 as she would benefit from a smaller, less stimulating environment. -However, according to progress notes, Resident #31 was found outside the facility on 11/10/24 and 1/19/25 (see record review above). 51163 II. Failed to ensure staff provided appropriate supervision and implemented care planned interventions for Resident #15 while smoking A. Facility policy and procedure The Traditional Tobacco and Electronic Smoking Device policy, dated 5/10/23, was provided by the CC on 2/6/25 at 8:08 p.m. It read in pertinent part, All residents who smoke or desire to smoke will be appropriately assessed to determine if the resident requires supervision and protective equipment during smoking. Smoking assessments and potential restrictions shall be completed upon admission, quarterly or at the time of unsafe smoking behavior or suspicion of smoking in an undesignated area or upon change of condition. The interdisciplinary team (IDT) will implement a care plan for all residents who smoke on the baseline care plan. A care plan is required for all smoking residents and any smoking materials. The smoking assessment will also identify those residents who require protective devices such as a non-combustable apron or blanket or any other protective device. Supervised smokers shall not be permitted to smoke without the direct supervision of a designated staff member, family member or volunteer. Direct supervision will be provided throughout the entire smoking period. Supervised smokers will have their smoking supplies secured at the nurse's station. B. Resident #15 1. Resident status Resident #15, age 69, was admitted on [DATE]. According to the February 2025 CPO, diagnoses included encephalopathy, type two diabetes, schizophrenia and major depressive disorder. The 1/6/25 MDS assessment revealed Resident #15 had moderate cognitive impairment with a BIMS score of nine out of 15. The resident required partial to moderate assistance with most of his ADLs. 2. Observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 9:55 a.m. Resident #15 was observed having his cigarette lit by another resident as he was standing beside her and smoking. An unknown staff member approached and watched the lighting of the cigarette and then returned to the inside of the building. Resident #15 was not wearing a smoking apron. On 2/4/25 at 4:12 p.m. CNA #7 was observed taking Resident #15 outside for a cigarette. Resident #15 was observed lighting his own cigarette while CNA #7 watched him. Resident #15 and CNA #7 moved over to the smoking bench and table. CNA #7 handed Resident #15 the ash tray and a long tube (the tubing was for the resident to inhale from the cigarette while the cigarette rested in the ashtray and ensured the resident did not have to hold the cigarette) that were already outside and on the table. Resident #15 did not use either the ash tray or the tubing and held the cigarette as he smoked.CNA #7 did not encourage or assist Resident #15 with placing the tubing on his cigarette. Resident #15's hands and arms were moving involuntarily and he was shaking. A smoking apron was lying on the bench next to Resident #15 but he did not put the apron on and CNA #7 did not ask Resident #15 put on the apron. CNA #7 remained outside with Resident #15 for the duration of the cigarette, however, CNA #7 was looking at her phone the entire time and was not observing the resident to ensure the cigarette did not drop hot ash on the resident. 3. Record review Resident #15's smoking care plan, revised 1/21/25, revealed the resident was a supervised smoker and was required to wear a smoking apron while smoking. Resident #15's 10/1/24 admission smoking assessment indicated the resident was a supervised smoker and was unable to light a cigarette safely independently. He was required to wear a smoking apron while smoking. Resident #15's 1/1/25 smoking assessment indicated the resident was a supervised smoker and was unable to light a cigarette safely independently. He was required to wear a smoking apron while smoking. -However, Resident #15's care plan and the smoking assessments did not indicate that Resident #15 was to use any other type of adaptive equipment while smoking (see observations above). C. Staff interviews The NHA and the CC were interviewed together on 2/6/25 at 7:16 p.m. The NHA said if Resident #15 used the tubing then he did not have to be supervised for the entire smoke break, however, he said staff did need to take him out and light his cigarette. If he used the tubing then he was not physically holding the cigarette because the cigarette stayed in the ashtray and he inhales through the other end of the tube. He said Resident #15 was supposed to use the tubing. The NHA said if Resident #15 did not use the tubing, staff needed to stay outside with him. -However, the use of the tubing was not included on Resident #15's care plan or smoking assessments (see record review above). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Failed to ensure care-planned interventions for falls were consistently implemented for Resident #54 A. Facility policy and procedure The Fall Management policy and procedure, dated 2/29/24, was provided by the CC on 2/6/25 at 8:08 p.m., It read in pertinent part, A fall reduction program will be established and maintained to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. The fall reduction program is characterized by four components: - Fall risk evaluation; - Care planning and implementation of interventions; - On going evaluation process quality assurance performance improvement (QAPI); and, - Commitment by caregivers to make it work. B. Resident #54 1. Resident status Resident #54, age 64, was admitted on [DATE]. According to the February 2025 CPO diagnoses included fracture of right patella, fracture of T11-T12 vertebra, epilepsy, schizophrenia, muscle weakness and repeated falls. The 12/18/24 MDS assessment indicated that Resident #54 had moderate cognitive impairment with a BIMs score of 12 out of 15. The assessment further indicated that he needed supervision or touching assistance for all of his transfers and ambulating and partial to moderate assistance with toileting and substantial to maximal assistance with dressing and personal hygiene. 2. Observations On 2/5/25 at 9:18 a.m. Resident #54 was sleeping in his bed. The resident was leaning far to the right and nearly off the side of his bed. His walker was seen outside of his room in the hallway. His bed was not in the lowest position. On 2/5/25 at 11:27 a.m. Resident #54 was sleeping in the same position as before and his bed was still not in the lowest position. His walker was seen outside of his room in the hallway. On 2/6/25 at 8:50 a.m. Resident #54 was sitting on the edge of his bed eating his breakfast. The resident's bed was not in the lowest position. On 2/6/25 at 12:14 p.m. Resident #54 was asleep in his bed. The resident's right leg was hanging over the edge of his bed and his bed was not in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 1:51 p.m. Resident #54 continued to sit on the edge of his bed eating his lunch. The resident's bed was not in the lowest position. His walker was in his room by his bed. 3. Record review The fall care plan, revised 9/23/24, revealed Resident #54 had a history of falls and was at risk for injuries due to falling. The interventions included making sure the resident was wearing appropriate footwear, anticipating and meeting the resident's needs, encouraging the resident to use the call light, ensuring the resident's room was clutter free and the resident's bed was in the lowest position when the resident was in the bed. The 2/3/25 nursing progress note revealed Resident #54 was found on the floor in his bathroom. The 2/4/25 nursing note indicated that Resident #54's fall precautions were maintained and the resident's bed was in the lowest position and the room was clutter free. The 2/4/25 interdisciplinary team (IDT) note indicated that the root cause of the 2/3/25 was due to a recent fracture. The note indicated interventions that were put in place included re-educating the resident of the importance of using his call light and using his wheelchair brakes when transferring. C. Staff interviews CNA #9 was interviewed on 2/6/25 at 2:00 p.m. CNA #9 said Resident #54's bed was not in the lowest position because he was a tall person and if the bed was in the lowest position, he would not be able to get up to go to the bathroom. He said Resident #54 was not on any fall precautions and he was able to ambulate on his own. -However, Resident #54's 12/18/24 MDS assessment indicated the resident needed supervision or touching assistance for all of his transfers and ambulating and partial to moderate assistance with toileting (see resident status above). RN #4 was interviewed on 2/6/25 at 4:20 p.m. RN #4 said Resident #54 was on fall precautions because he had a recent fall. He said when Resident #54 ambulated, he was supposed to be supervised and he was supposed to call for help before he got up. RN #4 said Resident #54's bed should be in the lowest position.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#52) of four residents reviewed for catheters of 47 sample residents. Specifically, the facility failed to: -Obtain physician's orders for the use of Resident #52's catheter; -Create a care plan addressing Resident #52's use of the catheter; and, -Maintain documentation for Resident #52's catheter care and maintenance. Findings include: I. Facility policy and procedure The Urinary Catheter Care policy and procedure, revised August 2022, was received from the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The nursing and interdisciplinary team should assess and document the ongoing need for a catheter that is in place. The following documentation should be recorded in the resident's medical record: the date and time that catheter care was given, the name and title of the individual giving catheter care, and all assessment data obtained when giving catheter care. II. Resident #52 A. Resident status Resident #52, age 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO) diagnoses included demyelinating disease of the central nervous system (a disorder that damages the myelin sheath-the protective covering around nerve fibers in the central nervous system), obstructive and reflux uropathy (a condition that affects the urinary tract, leading to an obstruction or blockage in the flow of urine), neuromuscular dysfunction of the bladder and a personal history of urinary tract infections (UTIs). The 1/7/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She was dependent on staff for most activities of daily living (ADLs). The MDS assessment indicated she had an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations and resident interview Resident #52 was interviewed on 2/4/25 at 9:03 a.m. Resident #52 said she had a urinary catheter to keep the urine away from her kidneys. Resident #52 said she had not had any issues with her catheter and had used the catheter for the last two to three months. Resident #52 said she had just recovered from a UTI. Resident #52 said the facility staff did not say how she had gotten the UTI but they gave her antibiotics for it. Resident #52 was lying in bed with the catheter bag clipped to the foot of her bed. On 2/6/25 at 8:30 a.m. licensed practical nurse (LPN) #1 was providing catheter care for Resident #52. LPN #1 filled a basin with warm water, washed her hands, pulled the privacy curtain and put on gloves. LPN #1 did not don (put on) a gown. LPN #1 removed Resident #52's incontinence brief. LPN #1 used a warm wet washcloth and wiped down the front of Resident #52's perineum from front to back and then wiped down her catheter with the same cloth. LPN #1 disposed of the washcloth. LPN #1 obtained a new washcloth and wiped the catheter towards the catheter bag then wiped back up the catheter tubing towards Resident #52's perineum. LPN #1 used the same cloth to wipe Resident #52's perineum and disposed of the washcloth. -LPN #1 did not don the appropriate personal protective equipment (PPE) to care for Resident #52's indwelling catheter Cross-reference F880: failure to follow infection control practices. C. Record review A review of the February 2025 CPO revealed the following order: Indwelling catheter., monitor for placement and function every shift, change the catheter for complications and prior to obtaining a urine sample as needed, provide catheter care and ensure a privacy bag was in place every shift, ensure the catheter was unobstructed, secured, and draining properly every shift. Change the catheter tubing and bag as needed. Replace graduated cylinder or urinal used for draining catheter bag every Friday night, ordered 2/6/25 at 9:26 a.m. (during the survey process). -Review of the comprehensive care plan did not reveal any focus or interventions related to the use of the indwelling urinary catheter. A hospital note, dated 10/13/24 at 2:43 p.m., revealed Resident #52 had a foley (indwelling urinary) catheter which the resident would keep after her discharge back to the facility. A progress note, dated 10/14/24 at 10:57 p.m., revealed Resident #52 returned to the facility from the hospital at 6:45 p.m. that evening. Resident #52 had an indwelling catheter which was draining clear yellow urine. A progress note, dated 10/15/24 at 5:53 a.m., revealed Resident #52 had a foley catheter in place and a urine output of 450 cubic centimeters (cc) of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 10/15/24 at 9:16 p.m., revealed Resident #52 had a foley catheter in place and a urine output of 1000 milliliters (ml). A weekly nursing note, dated 11/6/24 at 12:46 p.m., revealed Resident #52 used a foley catheter. A weekly nursing note, dated 12/23/24 at 9:40 p.m., revealed resident #52 used a foley catheter. Resident #52's urine was clear and yellow, and no odor was noted at that time. A weekly nursing note, dated 1/6/25 at 9:19 p.m., revealed Resident #52 used a foley catheter. Resident #52's urine was free of odor and yellow in color. A provider note, dated 1/17/25 at 1:43 p.m., revealed Resident #52 was seen by her provider after recent bloodwork revealed elevated white blood cell counts. Resident #52 denied having a fever but reported having burning urination, an intermittent cough and congestion. A urinalysis and culture were ordered. A provider note, dated 1/29/25 at 12:00 a.m., revealed Resident #52 was on antibiotics for five days for a UTI. Resident #52 said she was having urinary pain a few days prior which had resolved since starting the antibiotics. Resident #52 had a foley catheter in place which was draining clear yellow urine. A weekly nursing note, dated 1/31/25 at 8:10 p.m., revealed Resident #52 used a foley catheter. Review of the bladder elimination task for Resident #52 from 1/7/25 to 2/5/25 revealed the following: -Continence was not rated due to indwelling catheter was marked 37 times; -Incontinent was marked 17 times; and, -Continent was marked 10 times. D. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 2/5/25 at 2:21 p.m. CNA #5 said the CNAs emptied the catheter bags, gave the nurses the quantity of urine and the nurses charted the information. CNA #5 said the CNAs emptied the catheter bags every shift. Registered nurse (RN) #5 was interviewed on 2/5/25 at 3:39 p.m. RN #5 said catheter care was performed every day. RN #5 said the nurses or the CNAs could provide catheter care. RN #1 was interviewed on 2/5/25 at 4:31 p.m. RN #1 said the CNAs provided catheter care but the nurses could also do so if the CNAs were busy. RN #1 said the nursing staff provided Resident #52 catheter care whenever they changed her incontinence brief. RN #3 was interviewed on 2/5/25 at 4:55 p.m. RN #3 said catheter care was mostly done by the CNAs. RN #3 said the CNAs documented this in their catheter care task sheet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 2/5/25 at 5:07 p.m. CNA #1 said catheter care was documented in the electronic medical record (EMR) in the associated tasks. CNA #1 said catheter care should be performed and documented every shift. The CC was interviewed on 2/5/25 at 5:12 p.m. The CC said catheter care should be in the resident's orders, medication administration record (MAR) and the care plan. LPN #1 was interviewed on 2/6/25 at 8:40 a.m. LPN #1 said she washed her hands and put on gloves before performing catheter care. LPN #1 said she normally put on a gown as well. LPN #1 said when providing catheter care she should wipe from front to back and use a separate washcloth when moving from the perineum to the catheter. LPN #1 said when cleaning the catheter she should start at the perineum and wipe away (down the line toward the catheter bag). The DON was interviewed on 2/6/25 at 7:47 p.m. The DON said when providing catheter care, the nursing staff should wipe from the urethra down to the catheter bag and work from clean surfaces to dirty surfaces. The DON said the nursing staff needed to don a gown and gloves when providing catheter care. The DON said catheter care needed to be done every day and as needed, especially for Resident #52. The DON said the CNAs should empty the catheter bag but not clean it. The DON said the CNAs needed to wear a gown and gloves when emptying the catheter bag. The DON said the physician's order for catheter care was added on 2/6/25 and said it should have been added before then. The DON said there was not a catheter care plan in Resident #52's comprehensive care plan. The DON said the admission nurse missed the order for catheter care and the mistake just carried on. The DON said she had been pairing up with a staff member in the record-keeping department to try to do audits of residents' medical records.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50219 Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in two of four medication carts. Specifically, the facility failed to: -Ensure expired medications were removed from the medication cart; and, -Ensure injectable medications were labeled with the date they were opened. Findings include: A. Professional references The United States Food and Drug Administration (USFDA) Don't Be Tempted to Use Expired Medicines (revised 10/31/24), was retrieved on 2/12/25 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it. The Food and Drug Administration (FDA) Insulin Storage and Effectiveness (revised 9/19/17), was retrieved on 2/12/25 from fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency. It read in pertinent part, Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 (degrees) Fahrenheit (F) and 86 F for up to 28 days and continue to work. B. Facility policy and procedure The Storage of Medications policy, revised November 2020, was provided by the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they were received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations On 2/6/25 at 5:07 p.m. the medication cart on the second south hall was observed with registered nurse (RN) #6. The following items were found: -A bottle of vitamin C supplements, with an expiration date of December 2024; -A bottle of vitamin C supplements, with an expiration date of August 2024 ; -A bottle of fish oil supplements, with an expiration date of August 2024; -A bottle of vitamin D3 supplements, with an expiration date of January 2025; -A COVID-19 testing reagent, with an expiration date of December 2023; -A nicotine lozenge, with an expiration date of July 2024; -A bottle of calcium acetate, with an expiration date of October 2024; -A bottle of zinc sulfate, with an expiration date of September 2024; -A bottle of naproxen sodium, with an expiration date of March 2024; -Two bisacodyl suppositories, with an expiration date of May 2024; -A bottle of Prostat, with an expiration date of 10/24/24; and, -Five insulin injection pens for four different residents which were not labeled with the date they were opened; -Nine loose pills in the back of the top drawer; -Multiple loose pills in two other drawers of the medication cart. On 2/6/25 at 5:34 p.m. the medication cart on the north hall was observed with RN #4. The following items were found: -A bottle of thiamine supplements, with an expiration date of September 2024; -A bottle of oyster shell calcium supplements, with an expiration date of August 2024; and, -A bottle of Latanoprost ophthalmic solution, undated. IV. Staff interviews RN #4 was interviewed on 2/6/25 at 5:34 p.m. RN #4 said the night shift nursing staff went through and cleaned the medication carts each week. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 2/6/25 at 8:01 p.m. The DON said the over-the-counter medications on the medication carts should be reviewed every day. The DON said as soon as a resident was discharged , their old medications were discarded. The DON said she and another staff member went through the medication room to try to discard old medications. She said they had been falling behind with doing so because they were the only two staff members doing this task. The DON said she was trying to get the night shift nursing staff to go through the medication carts each night and discard any expired medications or medications from residents that had discharged . The DON said there should not be any loose pills in the medication carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen, activities room, and two of two nourishment refrigerators. Specifically, the facility failed to: -Ensure safe and appropriate storage of food items in the nourishment room refrigerators; and, -Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination in the main kitchen. Findings include: I. Failure to safely and appropriately store food items A. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE]. It revealed in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (,d+[DATE].17) B. Facility policy and procedure The Food Receiving and Storage policy and procedure, revised [DATE], was provided by the clinical consultant (CC) on [DATE] at 11:56 a.m. It read in pertinent part, Time/temperature control foods are stored at or below 41 degrees F. Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented. Refrigerated foods are labeled, dated and monitored so they are used by their' use-by' date, frozen, or discarded. Frozen foods are maintained at a temperature to keep the food frozen solid. All food items to be kept at or below 41 degrees F are placed in the refrigerator located at the nurse's station and labeled with a use by date. All foods belonging to residents are labeled with the resident's name, the item and the use by date. Refrigerators must have working thermometers and are monitored for temperature according to state-specific guidelines. Other opened containers are dated and sealed or covered during storage. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Observations and record review On [DATE] at 10:35 a.m., the following items were observed in the south hall nourishment refrigerator: -An open bottle of thickened apple juice, with an expiration date of [DATE]; -A container of yogurt, with an expiration date of [DATE]; -A container of milk, with an expiration date of [DATE]; -An unidentified food item rolled in aluminum foil in a plastic bag, dated [DATE]; -An open and partially used butter packet, undated; and, -A medical ice pack. On [DATE] at 9:21 a.m., the following items were observed in the north hall nourishment refrigerator: -An open container of applesauce, unlabeled and undated; and, -A nutritional frozen dessert cup which was thawed and easy to squeeze, undated. Instructions on the dessert cup revealed it was to be stored frozen and used within five days of thawing in the refrigerator. The refrigerator was 56 degrees F. A refrigerator temperature log for February 2025 was posted on the nourishment refrigerator. The refrigerator temperature was recorded as 58 degrees F each day from [DATE] through [DATE]. The temperature log had instructions written at the bottom which read in part, refrigerator temperature range is less than 41 degrees F, freezer temperature is less than 20 degrees F. Adjust setting if temperature is out of range. Verify the thermometer every three days. -There was no documentation on the refrigerator temperature log that indicated the temperature of the refrigerator was addressed when it was noted to be out of acceptable range. On [DATE] at 2:50 p.m., the following items were observed in the south hall nourishment refrigerator: -The same open bottle of thickened apple juice, with an expiration date of [DATE]; -The same container of yogurt, with an expiration date of [DATE]; -The same container of milk, with an expiration date of [DATE]; -The same unidentified food item rolled in aluminum foil in a plastic bag, dated [DATE]; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The same open and partially used butter packet, undated; and, -Several dumplings wrapped together in plastic wrap, unlabeled and undated. On [DATE] at 4:44 p.m., the following items were observed in the activities room refrigerator: -A bottle of dijon mustard, with an expiration date of [DATE]; -A bottle of yellow mustard, with an expiration date of [DATE]; -A jar of olives, with an expiration date of [DATE]; and, -A bottle of chocolate syrup, with an expiration date of [DATE]. -The activities director (AD) threw away the expired contents of the refrigerator during this observation. On [DATE] at 10:30 a.m., the February 2025 refrigerator temperature log on the south nourishment refrigerator only had one temperature recorded on [DATE]. No temperatures were recorded for [DATE] through [DATE]. D. Staff interviews Registered nurse (RN) #1 was interviewed on [DATE] at 9:16 a.m. RN #1 said the dietary staff or the night shift nurses checked the nourishment refrigerator temperatures. RN #1 said she was not sure who checked through the foods in the nourishment refrigerators or when that task was done. Certified nurse aide (CNA) #10 was interviewed on [DATE] at 10:13 a.m. CNA #10 said the dietary staff filled the nourishment refrigerators and the night shift nurses checked the refrigerator temperatures. CNA #10 said the dietary staff checked the nourishment refrigerator contents during the day. The AD was interviewed on [DATE] at 4:44 p.m. The AD said the activities staff and dietary staff shared responsibility for maintaining the contents of the activities refrigerator. The dietary manager (DM) was interviewed on [DATE] at 11:50 a.m. The DM said the north nourishment refrigerator was 53 degrees F. The DM said the unit needed a new refrigerator and she would alert the maintenance staff. The DM said the refrigerator temperature should be checked daily. The DM said the temperature of the refrigerator was above what it needed to be, as it needed to be below 41 degrees F. The DM said cold food needed to be kept below 41 degrees F. The DM said the facility nurses checked the refrigerator daily and should have notified the dietary staff about the temperatures. The DM said she reviewed the south nourishment refrigerator. She said the bottle of milk and thickened apple juice were expired and she threw them away. The DM said the contents and temperature of the refrigerator should be checked daily. The DM verified the refrigerator had only had its temperature monitored once in February 2025. The DM said she would do an inservice with the staff on recording the dates food items were opened. II. Failed to ensure ready-to-eat foods were handled in a sanitary manner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Professional reference The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE]. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (,d+[DATE].11) B. Observations During a continuous observation of the lunch meal service on [DATE], beginning at 10:40 a.m. and ending at 12:37 p.m. the following was observed: At 11:50 a.m. DA #1 donned (put on) a pair of gloves and began preparing two hamburgers. DA #1 retrieved a bag of hamburger buns, opened the bag and grabbed two hamburger buns with the same gloved hands. With the same gloved hands, DA #1 selected lettuce leaves and placed them on the hamburger buns. DA #1 repeated this process with onion slices using the same gloved hands. DA #1 opened a bag of potato chips and retrieved a handful of chips to put onto the plates with the hamburger buns with his gloved hands. DA #1 retrieved a new bag of potato chips, opened the bag and used the same gloved hands to grab another handful of chips to put on the plate with the hamburger buns. C. Staff interview The DM was interviewed on [DATE] at 9:51 a.m. The DM said ready-to-eat foods should be handled with clean gloves used only for one task.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption. Specifically, the facility failed to: -Ensure the resident's personal refrigerator temperatures were monitored correctly for appropriate temperatures; and, -Implement the facility policy for food brought by visitors and ensure food that was kept in residents' refrigerators had safe and sanitary storage. Findings include: I. Professional reference The Colorado Retail Food Regulations, ([DATE]) were retrieved on [DATE]. It read in pertinent part, Except during preparation, cooking, or cooling, time and temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less. (,d+[DATE].16) Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (,d+[DATE].17) The Food and Drug Administration (FDA) food code ([DATE]) were retrieved on [DATE] from https://www.fda.gov/food/fda-food-code/food-code-2022 revealed in pertinent part, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone (41 degrees to 135 degrees F) too long. II. Facility policy and procedure The Refrigerators and Freezers procedure and policy, revised [DATE], was provided by the clinical consultant (CC) on [DATE] at 11:56 a.m. It read in pertinent part, Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily. Supervisors are responsible for ensuring food items in refrigerators are not past use by or expiration dates. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Observations On [DATE] at 9:05 a.m., Resident #13's refrigerator contained the following items: -A container of rice, unlabeled and undated; and, -A bottle of chocolate syrup, dated [DATE] and the expiration date was obscured by marker. The thermometer in the refrigerator read 42 degrees Fahrenheit (F). The February 2025 temperature log on the refrigerator revealed the temperature had not been recorded on [DATE], [DATE] and [DATE] through [DATE]. The temperature recorded on [DATE] was 42 degrees F. -However, there were no indications that the staff member who recorded the temperature attempted to correct the temperature of the refrigerator. On [DATE] at 1:29 p.m., the temperature log on Resident #66's personal refrigerator had temperatures recorded for [DATE] through [DATE]. On [DATE] the refrigerator was recorded at 42 degrees F, on [DATE] it was 42 degrees F and on [DATE] it was 44 degrees F. The temperature was not recorded on [DATE] or [DATE]. The temperature was 42 degrees F at that time. -However, there were no indications that the staff member who recorded the temperature attempted to correct the temperature of the refrigerator. On [DATE] at 10:08 a.m., the temperature log on Resident #68's personal refrigerator did not have temperatures recorded on [DATE], [DATE] and [DATE] through [DATE]. The temperature of the refrigerator was 42 degrees F at that time. -However, there were no indications that the staff member who recorded the temperature attempted to correct the temperature of the refrigerator. IV. Resident interviews Resident #13 was interviewed on [DATE] at 9:08 a.m. Resident #13 said the facility's maintenance staff checked the temperature of his refrigerator but did not do it every day. Resident #13 said no one came in and checked through his refrigerator to see if things were expired. Resident #68 was interviewed on [DATE] at 10:08 a.m. Resident #68 said the facility's maintenance staff came and checked her refrigerator's temperature but did not do so every day. V. Staff interviews The dietary manager (DM) was interviewed on [DATE] at 9:51 a.m. The DM said refrigerators should be kept at 41 degrees F or below to keep food out of the danger zone for bacterial growth. The DM said any temperature above 41 degrees F was too warm and the refrigerator needed to be serviced. The DM said she checked multiple of the resident's refrigerators throughout the facility and found they had not had their temperature checked for several days according to their February 2025 temperature logs. The DM said the housekeeping staff checked the resident's refrigerators daily. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The environmental services director (ESD) was interviewed on [DATE] at 12:08 p.m. The ESD said the housekeeping staff were responsible for checking the temperatures of resident's personal refrigerators daily. The ESD said he was only told to have the housekeeping staff check the temperatures, not the refrigerators' contents. The ESD said it was a grey area which department was responsible for the refrigerators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection. Specifically, the facility failed to: -Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfecting resident rooms and high-frequency touched areas (call lights, door handles and handrails); -Ensure housekeeping staff performed appropriate hand-hygiene; -Ensure enhanced barrier precautions (EBP) were in place for Resident #52 and Resident #284; -Follow infection control procedures for catheter care; -Follow infection control procedures for endotracheal tube care; and, -Clean equipment between use with residents. Findings include: I. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 2/13/25 from https.//pubmed.ncbi.nlm.nih.gov. It read in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 2/13/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/pre (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ent/resource-limited/cleaning-procedures. html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised August 2013, was provided by the clinical consultant (CC) on 2/10/25 at 11:56 a.m. It read in pertinent part, Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Perform hand hygiene after removing gloves. C. Observations During a continuous observation on 2/5/25, from 9:43 a.m. to 10:11 a.m., housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER]. HK #1 removed his gloves from a previous room and donned (put on) a new set of gloves without performing hand hygiene. HK #1 entered room [ROOM NUMBER] and began spraying the entire surface of the toilet with Clorox hydrogen peroxide cleaner. HK #1 returned to his cart, removed his gloves and donned a new pair of gloves without performing hand hygiene. HK #1 retrieved a rag from a bin with cleaning solution and began wiping the door handles, light switch, sink area, and sink faucet. HK #1 pulled a chisel from his pants pocket and scraped something on the sink surface before returning it to his pants pocket. HK #1 wiped over the area he chiseled with the rag. HK #1 did not sanitize the chisel. HK #1 returned to his cart, removed his gloves and donned a new set of gloves without performing hand hygiene. HK #1 grabbed a new rag and began to wipe down the bedside table on side B of the room. HK #1 retrieved the chisel from his pants pocket, used it to scrape something on the side table, then returned the chisel to his pants pocket. HK #1 used the rag to wipe over the area he had scraped. HK #1 then used the chisel to scrape something on the floor underneath the bedside table before returning the chisel to his pants pocket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-HK #1 did not disinfect high-touch areas such as the resident's call light or remotes. HK #1 returned to his cart, removed his gloves and donned a new set of gloves without performing hand hygiene. HK #1 took a mop head out of a bin with cleaning solution and put it on the floor in side A. HK #1 then pushed the mop into Side B and began mopping. HK #1 used the chisel from his pocket to scrape the floor in several areas. HK #1 wiped the chisel along the back of the mop head before returning it to his pants pocket. HK #1 used the mop to push crumbs and a pillowcase from side B to side A and into the hallway. HK #1 used the same mop head to mop side A. -HK #1 failed to mop the two sides of the room separately. HK #1 returned to his cart, removed his gloves and donned new ones without performing hand hygiene. HK #1 grabbed two new rags from the cleaning solution bin and began to wipe down the sink area, the paper towel holder, the walls in the bathroom, then the bathroom handrail. HK #1 used a new rag to wipe the base of the toilet and the outside of the toilet bowl. HK #1 returned to the cart, removed his gloves and donned a new pair of gloves without performing hand hygiene. HK #1 grabbed a new rag from the cleaning solution bin, removed the raised toilet seat and set it on the bathroom floor, wiped the toilet flusher, the top of the toilet seat, bottom of the toilet seat and the rim of the toilet. HK #1 then began wiping the bottom side of the raised toilet seat before wiping down the top side of the raised toilet seat with the same rag. -HK #1 did not wipe the handles of the raised toilet seat. HK #1 removed his gloves, retrieved the Clorox hydrogen peroxide spray and sprayed the inside of the toilet bowl. HK #1 donned a new set of gloves, retrieved the toilet brush from the cart, and began scrubbing the inside of the toilet bowl. HK #1 put the toilet brush back onto the housekeeping cart. -HK #1 did not disinfect the toilet brush after use. HK #1 retrieved a new mop head, placed it on the bathroom floor and began mopping the bathroom. HK #1 used the chisel to scrape fecal material off of the bathroom floor. HK #1 wiped the chisel on the top of the mop head several times before wiping the chisel on his pants and placing the chisel back into his pocket. HK #1 then used the mop to sweep pieces of feces from the bathroom through side A of the room and into the hallway. HK #1 said the material he chiseled off the ground was feces. During a continuous observation on 2/6/25, from 9:22 a.m. to 9:44 a.m., HK #2 was observed cleaning room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:22 a.m. HK #2 finished cleaning room [ROOM NUMBER], removed her gloves and donned a new set of gloves without performing hand hygiene. HK #2 entered room [ROOM NUMBER] and began cleaning. HK #2 went into the bathroom and collected the trash bag from the trash can, grabbed a paper towel and removed something from the sink, then used the same gloved hand to move one of the resident's walkers by the handle. HK #2 returned to her cart, removed her gloves and donned a new set without performing hand hygiene. HK #2 grabbed a rag from the bin with cleaning solution and began wiping the dresser for side A and the top of the cart used to hold personal protective equipment (PPE). With the same gloved hands, HK #2 grabbed a new rag and wiped the area around the sink. HK #2 then used the same rag to wipe a small area of the outside portion of the door handle. HK #2 retrieved a new rag with the same gloved hands and began wiping the bedside table in side B of the room. The bedside table was mostly covered with the resident's personal items, which HK #2 did not move but instead wiped the available surface area of the table. -HK #2 did not disinfect the high-touch surfaces on side A or side B of the room including call lights, light switches and remotes. HK #2 returned to her cart, removed her gloves and donned new gloves without performing hand hygiene. HK #2 grabbed a toilet brush and a new rag from the bin with cleaning solution. HK #2 hung the toilet brush from the hand rail in the bathroom, squeezed the cleaning solution out of the rag and into the toilet, and used the same rag to clean the sink area in the bathroom. HK #2 used the toilet brush to scrub the bowl of the toilet, then used the same rag to clean the underside of the seat, the rim of the toilet bowl, then the top of the toilet seat and the toilet basin. HK #2 returned the toilet brush back to her cart without disinfecting it. -HK #2 did not disinfect high-touch surfaces in the bathroom including the sink faucet, the hand rail in the bathroom, the soap dispenser or the toilet flusher. HK #2 grabbed a mop pad and put it onto the B side and began to mop that side. HK #2 used the mop to sweep debris including cotton gauze and a rubber band through side A into the hallway. HK #2 then used the same mop pad to mop the A side. HK #2 retrieved a new mop head and put it on the bathroom floor and mopped the bathroom. HK #2 lifted and carried the mop through the room, removed the mop head, put her equipment onto the cart and removed her gloves. HK #2 knocked on the door to room [ROOM NUMBER] and donned a new pair of gloves without performing hand hygiene. HK #2 then began cleaning room [ROOM NUMBER]. D. Staff interviews The environmental services director (ESD) was interviewed on 2/6/25 at 12:08 p.m. The ESD said the housekeeping staff should start at the sink in the room and work from dirtiest surfaces to cleanest surfaces. The ESD said the housekeeping staff should start at the sink, then clean the bathroom, then the B side of the room and the A side last. The ESD said the housekeepers had a specific toilet cleaner they used to clean the bowl of the toilet. The ESD said he did not know the exact steps the housekeepers followed, but said they should wipe the toilet handle, then the seat to prevent transferring bacteria from the seat to the handle. The ESD said the toilet scrub brush should be sanitized between each room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ESD said the housekeeping staff should use one mop head for side A and one mop head for side B. The ESD said the housekeeping staff should use hand sanitizer after removing dirty gloves and before putting on clean gloves. The ESD said the housekeeping staff should use a disinfectant spray and rag to wipe all high-touch surface areas. The ESD said he knew HK #2 was using a chisel when cleaning the rooms. He said he assumed HK #2 disinfected the chisel between use. The CC was interviewed on 2/6/25 at 6:01 p.m. The CC said the housekeeping staff should perform hand hygiene before entering a resident's room and before each glove change and should change their gloves frequently. The CC said it was not an acceptable practice to move from the bathroom to the room with the same mop head. The CC said high-touch surfaces should be cleaned daily with a disinfectant solution. II. EBP failures A. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 2/13/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care: any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, revised March 2024, was provided by the CC on 2/10/25 at 11:56 a.m. It read in pertinent part, EBPs are used as an infection prevention and control intervention to reduce the transmission of MDROs. Gloves and gown are applied prior to performing high-contact resident care activities. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Observations On 2/5/25 at 11:45 a.m. an EBP sign was observed on Resident #284's door. Registered nurse (RN) #2 was providing tube feeding care for Resident #284. RN #2 entered Resident #284's room performed hand hygiene and donned gloves. He raised the head of Resident #284's bed. RN #2 pulled back Resident #284's gown and opened the gastrostomy tube (G tube) cover. He then connected the tube feeding tubing to the open G tube port and started the tube feeding. He then disposed of supplies in the trash, removed his gloves and performed hand hygiene. -RN #2 did not don a gown before touching the patient, tube feeding supplies or the G tube port. On 2/5/25 at 2:21 p.m. certified nurse aide (CNA) #5 was observed as she finished emptying Resident #52's catheter bag. CNA #5 was wearing gloves but was not wearing a gown. There was no sign indicating Resident #52 needed EBP on her door and there was no PPE observed inside or outside of the resident's room (which was indicated in the facility's policy and interviews as the facility's process for identifying residents on EBP - see facility policy above and interviews below). On 2/6/25 at 8:30 a.m. licensed practical nurse (LPN) #1 was providing catheter care for Resident #52. Resident #52's room did not have an EBP sign on the door. LPN #1 filled a basin with warm water, washed her hands, pulled the privacy curtain and put on gloves. LPN #1 did not don a gown. -LPN #1 did not don the appropriate PPE to care for Resident #52's indwelling catheter. D. Staff interviews RN #2 was interviewed on 2/5/25 at 11:50 a.m. RN #2 said before touching a resident with a tube feeding hand hygiene should be performed and gloves should be donned. He said if there was a risk of blood or body fluids being sprayed a mask should be used. He said he was not aware of the EBP outside of the door. He said he was not aware that a gown needed to be used for residents on EBP. CNA #5 was interviewed on 2/5/25 at 2:21 p.m. CNA #5 said the CNAs only wore gloves to empty the resident's catheter bags if the resident did not have anything infectious. She said the CNAs did not wear gowns when providing catheter care. RN #1 was interviewed on 2/6/25 at 9:16 a.m. RN #1 said EBP was used for residents with wounds or urinary catheters. RN #1 said the EBP signs on the resident's doors indicated the nursing staff needed to wear a gown and gloves. RN #1 said EBP were to protect the workers and other residents in case the resident with EBP had an infection. CNA #10 was interviewed on 2/6/25 at 10:13 a.m. CNA #10 said EBP was used for residents with catheters. CNA #10 said EBP meant the staff needed to wear gloves only when they were specifically working with the resident's catheter or indwelling line, but not when providing other high-contact care. CNA #10 said the nursing staff only needed to wear gloves and not a gown when providing catheter care. LPN #1 was interviewed on 2/6/25 at 8:40 a.m. LPN #1 said she normally put on a gown on when providing catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #6 was interviewed on 2/6/25 at 3:10 p.m. CNA #6 said she looked for the EBP signs on resident's doors to see what PPE she needed to put on when working with those residents. The CC was interviewed on 2/6/25 at 6:01 p.m. The CC said EBP were used for any residents with chronic wounds or indwelling devices. The CC said the need for EBP was identified on admission. The CC said the residents that needed EBP had a sign outside their door that indicated they needed EBP and a bin of PPE outside of their room. The CC said anyone that entered the room to provide direct care needed to don a gown and gloves. The CC said EBP should be indicated in the resident's care plan. III. Catheter care failures A. Facility policy and procedure The Urinary Catheter Care policy and procedure, revised August 2022, was received from the CC on 2/10/25 at 11:56 a.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. B. Observations On 2/6/25 at 8:30 a.m. LPN #1 was providing catheter care for Resident #52. LPN #1 filled a basin with warm water, washed her hands, pulled the privacy curtain and put on gloves. LPN #1 did not don a gown. LPN #1 removed Resident #52's incontinence brief. LPN #1 used a warm wet washcloth and wiped down the front of Resident #52's perineum from front to back and then wiped down her catheter with the same cloth. LPN #1 disposed of the washcloth. LPN #1 obtained a new washcloth and wiped the catheter towards the catheter bag then wiped back up the catheter tubing towards Resident #52's perineum. LPN #1 used the same cloth to wipe Resident #52's perineum and disposed of the washcloth. -LPN #1 wiped the catheter tubing from the catheter bag to the perineum -LPN #1 used the same washcloth to wipe Resident #52's perineum before wiping down the catheter tubing. C. Staff interviews LPN #1 was interviewed on 2/6/25 at 8:40 a.m. LPN #1 said she washed her hands and put on gloves before performing catheter care. LPN #1 said she normally put on a gown as well. LPN #1 said when providing catheter care she should wipe from front to back and use a separate washcloth when moving from the perineum to the catheter. LPN #1 said when cleaning the catheter she should start at the perineum and wipe away (down the line toward the catheter bag). The director of nursing (DON) was interviewed on 2/6/25 at 7:47 p.m. The DON said when providing catheter care, the nursing staff should wipe from the urethra down to the catheter bag and work from clean surfaces to dirty surfaces. The DON said the nursing staff needed to don a gown and gloves when providing catheter care. 51163 IV. Tracheostomy failures (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Professional reference Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), chapter 33, page 1437, Performing Tracheostomy or Endotracheal Suctioning. It read in pertinent part [NAME] a nonsterile glove and face shield or goggles. Test the suction equipment by oscillating the connection tubing. Remove and discard gloves. Perform hand hygiene. Open the suction catheter kit. Maintain sterility of the inside of the suction kit. [NAME] gloves, consider your dominant hand clean and your nondominant hand as contaminated. Pour the sterile saline solution into a sterile container. Pick up the suction catheter with your dominant hand and attach it to the connection tubing. Do not touch the connection tubing with your dominant hand. B. Observations and interviews On 2/6/25 at 10:12 a.m. RN #2 was observed providing suctioning for Resident #284's tracheostomy. RN #2 said the procedure could be performed as a clean or sterile procedure and that he tried to be as sterile as possible. RN #2 laid all of the prepackaged sterile equipment on Resident #284's bedside table without cleaning the table or removing the items that were already on the bedside table. RN #2 did not designate a clean area and dirty area. RN #2 proceeded to wash his hands for approximately 12 seconds. He dried his hands and opened a trash bag and put it in the trashcan. He then washed his hands again for approximately 10 seconds and opened the box of gloves and put on a pair of the gloves. He then touched the privacy curtain, touched the bed control, pulled out the pulse oximeter from his pocket, touched the resident's hand, touched the tracheostomy tubing that was still connected to the resident and touched the bedside table. The package of suctioning equipment fell to the floor. He then picked up the package of suctioning equipment from the floor, opened the sterile suctioning equipment, grabbed his pen out of his pocket, raised the head of the bed and removed his gloves. Without performing hand hygiene, he put on his gown, opened and poured the distilled water into the sterile container. He then put on gloves without performing hand hygiene. He treated his left hand as his dirty hand. The tracheostomy tubing and tracheostomy mask fell to the floor. He picked up the tubing from the floor and removed the tracheostomy mask from the end of the tubing with his right hand, which was his sterile hand. He began to suction using both hands. He used his right hand to touch the resident and to check the pulse oximeter. He then grabbed the tracheostomy mask with his right hand, went to the sink and rinsed the tracheostomy mask off using water. He then said that he thought it was clean enough. He used his right hand to dry the mask with a paper towel. He then used his left hand to open and dig through all of Resident #284's bedside table drawers looking for a new tracheostomy mask. He touched the tracheostomy mask with both hands. He attached the tubing to the mask and put the tracheostomy mask onto Resident #284's tracheostomy. RN #2 then took off his gloves and washed his hands. D. Staff interview The CC was interviewed on 2/6/25 at 6:31 p.m. The CC said when the staff were completing tracheostomy suctioning, it was important to establish a clean area. She said the person doing the suctioning should have a clean hand and a dirty hand. She said that hand hygiene should be done before putting on sterile gloves. (continued on next page)

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