STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065298	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Pointe Care Center	1655 Yarrow St Lakewood, CO 80214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to honor resident choices for one (#8) of three residents out of 45 sample residents. Specifically, the facility failed to ensure Resident #8's preference was honored by getting her dressed prior to Bible study. Findings include: I. Resident #8 A. Resident status Resident #8, age 88, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure with hypoxia (when the blood does not have enough oxygen), chronic obstructive pulmonary disease (lung disease that blocks airflow making it hard to breathe), bipolar disorder unspecified and Alzheimer's disease unspecified. The 5/6/24 minimum data set (MDS) assessment revealed that 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 all activities of daily living (ADL), including dressing, incontinence care and personal hygiene. The assessment indicated that it was somewhat important to her that she chose what clothes to wear every day and very important to her to do her favorite activities. B. Resident observations and interviews On 9/23/24 at 10:30 a.m. Resident #8 was lying in bed dressed in a hospital gown. There were three individuals in her room, including her spouse. They were engaged in Bible study. Resident #8 was interviewed on 9/23/24 at 1:29 p.m. Resident #8 was still wearing a hospital gown. She said she was not always able to get dressed every day, even though it was her preference to get dressed daily. She said she particularly wanted to be dressed in her dress and ready for the day for Bible study, which took place once per week. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 said she had to participate in Bible study that day while dressed in her hospital gown. She said the facility staff did not get to her in time to get her dressed. She said she felt embarrassed because she was not in her dress for Bible study, but instead was wearing a hospital gown. Resident #8 said her preference was to get dressed in a dress every day. She said, at least once or twice a week, the staff was not able to get her dressed. She said she thought the facility staff were aware of her preference to get dressed every day. Resident #8 was interviewed a second time on 9/26/24 at 9:00 a.m. Resident #8 said Bible study took place every Wednesday at 10:00 a.m. However, she said there were times in which it was rescheduled and it would take place on another day. C. Record review The ADL care plan, revised 6/27/23, documented Resident #8 had an ADL self-care deficit due to impaired balance and pain. It documented that Resident #8 preferred to get up in the morning between 7:00 a.m. and 7:30 a.m. The Kardex (nursing tool that summarizes resident information regarding daily schedules and interventions) documented Resident #8's preference was to be up and dressed for Bible study. II. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 9/26/24 at 9:33 a.m. CNA #4 said resident preferences were documented on the Kardex or given through a report from the previous shift. She said after working with residents for a long time, she was able to get to know their preferences. CNA #4 said Resident #8 wanted to get dressed everyday but did not like to get out of bed everyday. She said she did not know the date or time of the Bible study in which Resident #8 participated. She said she did not know Resident #8 was involved in a Bible study, but knew a couple of people would visit her a couple of times per week. The social services director (SSD) was interviewed on 9/26/24 at 10:00 a.m. The SSD said Resident #8 did not come out of her room very often. She said she did not know Resident #8 attended a Bible study in her room and she did not know if she liked to get dressed in the morning. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 9/26/24 at 2:38 p.m. The NHA said every residents' preferences should be honored and documented on the Kardex for the CNAs to reference. The NHA said he knew Resident #8 participated in a Bible study but he did not know what day and time it occurred. The NHA said he would put a new system in place of a binder kept at the nursing station which would include every residents' specific preferences to ensure each residents' preferences would be honored.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 50853 Based on observations and interviews the facility failed to ensure that residents personal funds accounts were managed adequately for the facility and accessible to the residents. Specifically, the facility failed to ensure residents were able to access their personal funds accounts on the weekend. Findings include: I. Resident interviews Resident #27 was interviewed on 9/23/24 at 11:48 a.m. Resident #27 said she could only access her personal funds account when the lady in the front office was in the facility. Resident #27 said she could not get money from her personal funds account on the weekends. Resident #16 was interviewed on 9/26/24 at 11:32 a.m. Resident #16 said residents could not get money from their personal funds account on the weekends. Resident #16 said if residents wanted money for the weekend, they had to ask for the money on Friday. II. Observations -On 9/23/24, 9/24/24 and 9/25/24 there was not a sign posted in the facility regarding resident banking hours. On 9/26/24 at 1:40 p.m. a sign was posted on the wall next to the business office. The sign indicated resident banking hours were Monday through Friday from 10:30 a.m. to 11:00 a.m. At the very bottom of the sign, in very small print, it indicated money could be accessed in emergencies by contacting the nursing supervisor on duty. III. Staff interviews The business office manager (BOM) was interviewed on 9/25/24 at 2:18 p.m. The BOM said resident banking hours were from 10:30 a.m. to 11:00 a.m. Monday through Friday but the residents could access their personal needs money any time she was in the office. The BOM said there was also a lock box where personal funds account money was kept for emergencies. The BOM said the nursing supervisor on duty on the weekends could access the lock box, however, she said the lock box was broken and the facility needed a new one. The BOM said she used to have a sign by her door with posted banking hours but it fell down and broke. The BOM said the sign indicated residents could contact the nursing supervisor on duty if they needed money for emergencies. She said the sign fell down around the first of August and the frame needed to be repaired. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #2 was interviewed on 9/26/24 at 10:38 a.m. RN #2 said she did work some weekends. She said she did not know if residents could access personal funds account money on weekends. RN #2 said activities staff usually had ways to get things residents needed. RN#2 said she could message her supervisor if a resident needed something. The BOM was interviewed again on 9/26/24 at 10:45 a.m. The BOM said the lock box used to be kept in one of the medication carts and was accessible to the nursing supervisor on duty on weekends. The BOM said the facility needed to get a new lock box because batteries corroded the old one. She said it had been a few months since the box was broken and money had not been available for residents to access on weekends. The social services consultant (SSC) was interviewed on 9/26/24 at 1:40 p.m. The SSC read the sign posted by the business office and said the sign indicated personal funds accounts were accessible Monday through Friday from 10:30 a.m. to 11:00 a.m. She said it did not appear residents could access money on weekends. She said the very small print at the bottom of the sign indicated money could be accessed in emergencies through the nursing supervisor. The SSC said she could barely read the small print and the facility would update the sign with a larger print. The nursing home administrator (NHA) was interviewed on 9/26/24 at 2:38 p.m. The NHA said residents should be able to access their personal funds accounts on the weekend. The NHA said he was not informed until this week (during the survey) that the lock box was broken. He said he told staff to replace it.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to notify the resident's representative when required for one (#20) of one resident reviewed out of 45 sample residents. Specifically, the facility failed to ensure Resident #20's representative was notified of her medical appointments. Findings include: I. Resident #20 A. Resident status Resident #20, age 86, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included fracture of the right femur (large bone in the upper leg), cerebral infarction (stroke), dysphagia (difficulty swallowing), muscle weakness and Parkinsonism (a general term for neurodegenerative diseases that cause similar motor symptoms, such as rigidity, tremors, and slow movement). The 7/16/24 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 required substantial to maximal assistance with transfers and used a wheelchair for mobility. B Resident interview Resident #20 was interviewed on 9/23/24 at 3:54 p.m. Resident #20 said she had a doctor's appointment with a specialist last week (week prior to survey) but staff did not tell her ahead of time or notify her daughter, who was her medical power of attorney (POA), about the appointment. Resident #20 said she wanted her representative to be notified of all medical appointments. C. Resident representative interview Resident #20's representative was interviewed on 9/26/24 at 12:21 p.m. The representative said she was the resident's medical POA and she told the staff to call her for any medical issues and appointments. She said she had informed the social services director (SSD) and the director of nursing (DON). She said sometimes the facility called her brother, who was the financial POA but he did not relay information to her. The representative said Resident #20 told her she went to a doctor's appointment last week (week prior to survey) but staff did not call her to notify her of the appointment. She said she did not know what the appointment was for. The representative said Resident #20 also had a medical appointment approximately one month ago (August 2024) and she was not notified of that appointment either. D. Record review (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's electronic medical record (EMR) revealed that Resident #20 had a financial POA and a medical POA listed as contacts. The 8/15/24 progress note revealed Resident #20 had an appointment with an orthopedist on 8/15/24. -The progress note did not indicate the resident's representative was notified of the appointment. The 9/16/24 progress note revealed Resident #20 had an appointment with an orthopedist on 9/16/24. -The progress note did not indicate the resident's representative was notified of the appointment. II. Staff interviews The SSD was interviewed on 9/26/24 1:34 p.m. The SSD said she arranged medical appointments with outside providers and contacted resident representatives to notify them of appointments. The SSD said Resident #20 had an appointment on 9/16/24 with the orthopedist and she notified the resident's financial POA of the appointment. The SSD said the day after the appointment the medical POA told her to call her regarding all appointments and not the financial POA. The SSD said she was not aware that the medical POA had talked to someone in the past about being notified of the resident's appointments. The DON was interviewed on 9/26/24 at 4:51 p.m. The DON said the SSD had been helping with the arrangement of medical appointments and contacting resident representatives. The DON said they contacted the POA or guardian to notify them of appointments. He said if a resident had a financial and a medical POA they should contact the medical POA for appointments. The DON said Resident #20's representative did not talk to him about this in the past, but he said the medical POA should have been notified of the appointments.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations and interviews, the facility failed to ensure residents' personal privacy for one (#13) of one resident reviewed for privacy out of 45 sample residents. Specifically, the facility failed to ensure privacy during care for Resident #13 by providing the resident with a privacy curtain. Findings include: I. Resident #13 A. Resident status Resident #13, age 72, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, chronic obstructive pulmonary disease (lung disease narrowing the airways making it hard to breathe) and muscle weakness. The 7/9/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required supervision or touching assistance for all activities of daily living (ADL). B. Resident interview and observation Resident #13 was interviewed on 9/23/24 at 1:52 p.m. Resident #13 said he received treatment for his groin every day. He said he was afraid that someone would walk into the room while he was exposed, when the treatment was being provided, because he did not have a privacy curtain. -During the interview, observation of Resident #13's room revealed the resident did not have a privacy curtain. II. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 9/26/24 at 9:33 a.m. CNA #4 said Resident #13 was mostly independent with his ADL care. She said he received treatment to his groin from the nurses. CNA #4 said she had not realized Resident #13 did not have a privacy curtain. She said she did not know how the resident was provided privacy during the treatment since he did not have a privacy curtain. Licensed practical nurse (LPN) #3 was interviewed on 9/26/24 at 10:56 a.m. LPN #3 said the evening shift nurse was assigned to apply lotion to Resident #13's groin. LPN #3 said Resident #13 did not have a privacy curtain in his room. She said she would ask the resident to go into the bathroom for privacy during the treatment because there was not a privacy curtain in his room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 9/26/24 at 2:38 p.m. The NHA said every resident should have a privacy curtain. He said facility staff should notify him or the maintenance department if a resident did not have a privacy curtain. The NHA said he was not aware Resident #13 did not have a privacy curtain. He said he would get a curtain put up immediately so the resident was provided privacy during his treatments and with his daily care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to provide a clean, comfortable and homelike environment for one (#91) of one resident out of 45 sample residents and resident rooms on four of four hallways. Specifically, the facility the facility failed to: -Ensure a homelike environment was created for Resident #91 by personalizing his room; -Ensure resident rooms and bathrooms on four of four hallways received necessary maintenance repairs; and, -Ensure hallways and dining rooms received necessary maintenance repairs. Findings include: I. Facility policy and procedure The Homelike Environment policy and procedure, revised February 2021, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:01 p.m. It revealed in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment, comfortable (minimum glare) yet adequate (suitable to the task) lighting, inviting colors and decor, personalized furniture and room arrangements, clean bed and bath linens that are in good condition, pleasant, neutral scents, plants and flowers, where appropriate, comfortable and safe temperatures (71 degrees Fahrenheit (F) to 81 degrees F) and comfortable sound levels. II. Failure to personalize Resident #91's room A. Resident status Resident #91, age 76, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified cataract (clouding of the clear lens of the eye and sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The 6/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) of three out of 15. He required supervision with all activities of daily living (ADLs). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment indicated it was somewhat important for him to have books, newspapers and magazines to read, to be able to listen to music he enjoyed, to do his favorite activities, to be able to go outside and very important to be around animals. B. Observations On 9/23/24 at 3:15 p.m. Resident #91 was in his room sitting on his bed. His call light was laying on the floor between the bed and the wall, inaccessible, with his bed pushed up against the wall. When the call light was pulled from the floor the push button was not connected, therefore the call light was not functional. The A side of the room's call light was strung up over the top of what appeared to be a television wall mount and out of reach of Resident #91. Resident #91 did not have a roommate. Resident #91's room was bare with nothing on the walls. The chest of drawers was missing a drawer, there were no towels near the sink, and there was not a trash bag in his trash receptacle. A small box (approximately 12 inches by 8 inches) was observed to be full of what appeared to be the resident's belongings on the floor, next to the chest of drawers. The bedside table had his dirty black tennis shoes sitting on top of it with the television remote inside his shoe. C. Record review The activities care plan, revised on 4/4/24, documented Resident #91 used to collect rocks, minerals and jewelry. It revealed that he used to show off his canvas paintings and jewelry to staff members. It further revealed that he loved dogs and used to own terriers throughout his life. The 3/22/24 activity assessment documented Resident #91's preferences included having books, magazines and newspapers to read, being able to listen to music, doing his favorite activities, going outside and being around animals. D. Staff interviews Certified nurse assistant (CNA) #4 was interviewed on 9/26/24 at 9:10 a.m CNA #4 said the walls in Resident #91's room were bare with no decorations. She said Resident #91 liked to put things in boxes. -However based on the observation above, Resident #91 only had a very small box of belongings in the room. CNA #4 said the housekeeping and the activities departments were responsible for helping residents personalize their rooms. CNA #4 said Resident #91's call light was on the floor between the bed and the wall and it should be on the bed and accessible to Resident #91. The activities director (AD) was interviewed on 9/26/24 at 10:00 a.m. The AD said she could not remember if Resident #91 had anything on the walls in his room. She said she recalled a box with paintings in it, but she could not remember if the resident had any other personal items. She said Resident #91's room was dark. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AD said she had printed a picture of Resident #91's family and gave it to social services to hang up in his room. She said she could not remember when that had occurred, or if social services had hung up the picture. The AD said she did not know which department was responsible for assisting in the personalization of resident rooms. The social services director (SSD) and the social services consultant (SSC) were interviewed on 9/26/24 at 11:08 a.m. The SSD said Resident #91 was into painting and that he had some pictures on the wall, but she said she had not been in his room recently. She said the social services assistant had hung pictures up in Resident #91's room. She said she was not aware there was nothing on the walls in Resident #91's room. She said she was not aware which department's responsibility it was to assist the resident in personalizing his room. The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 9/26/24 at 2:38 p. m. The NHA said the facility took an interdisciplinary team (IDT) approach to personalizing resident rooms. He said there was not one department assigned to assist residents in the personalization of their rooms. He said the facility would provide donated items and talk to family members to send or bring in the resident's personal effects. The NHA said he was unaware the walls in Resident #91's room were bare, had a broken chest of drawers, did not have any towels at the sink and did not have a trash bag in the receptacle. He said he would meet with the IDT to ensure Resident #91's room was fixed and he was provided the supplies he required to ensure his room was personalized. 48114 III. Failure to ensure resident rooms, hallways and dining rooms received necessary maintenance repairs A. Observations and resident interviews On 9/25/24 at 8:54 a.m. the door frame to the entrance of room [ROOM NUMBER] was observed to be chipped. The toilet in the bathroom of room [ROOM NUMBER] did not flush and there was no string on the call light by the toilet. The resident who resided in room [ROOM NUMBER] said she had to reach down inside of the tank and pull the chain in order for the toilet to flush. On 9/25/24 at 8:52 a.m., across from room [ROOM NUMBER], the baseboards were observed to be missing on both sides of the entrance way into the physical therapy room. On 9/25/24 at 8:47 a.m. the window blinds to room [ROOM NUMBER] were observed to be broken off and missing. The resident who resided in room [ROOM NUMBER] said he reported the broken blinds to the maintenance department and was told there was an order to replace all the blinds in the facility. He said he did not like how the light came through the broken blinds and he would like for them to be replaced. He said the light could be bothersome to him. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 8:46 a.m. the light fixture outside of room [ROOM NUMBER] was observed to be cracked and falling off the ceiling. On 9/25/24 at 8:56 a.m. the 400 hallway was observed to have carpet with several stains on it. On 9/25/24 at 8:57 a.m. the entrance room [ROOM NUMBER] was observed to have three tiles that were broken off and missing. In the center of the room there was a small hole in the floor tiles that it was chipping away. There was a big crack which extended from the hole that affected six other floor tiles. The bathroom in room [ROOM NUMBER], around the base of the toilet, was observed to be missing one tile. The resident who resided in room [ROOM NUMBER] said the hole in the tile often made her wheelchair wheels get stuck. She said if the facility would fix the tile it would be nice. On 9/25/24 at 9:03 a.m. the call light alert box over the entrance to room [ROOM NUMBER] was observed to be coming off the ceiling. On 9/25/24 at 9:10 a.m. room [ROOM NUMBER] was observed to have one curtain hanging from the left side of the window and no curtain on the right side of the window. On 9/25/24 at 9:15 a.m. the heater vent along the two walls by the four windows in the secure unit dining room was observed to be completely off the wall and on the floor. Two walls in the dining room by the dining room tables were chipped and needed to be repainted. On 9/25/24 at 9:21 a.m. the four plug outlet attached to the wall next to bed #2 in room [ROOM NUMBER] was observed to be coming off the wall. One of the standing four dresser drawers in the room had one drawer that was missing. On 9/25/24 at 9:18 a.m. room [ROOM NUMBER]'s window blinds were observed to be broken off and missing. On 9/25/24 at 9:25 a.m.the ceiling where the privacy curtain rod was hanging in room [ROOM NUMBER] was observed to be removed and the drywall was peeling off. The resident who resided in room [ROOM NUMBER] said the ceiling had been peeling off for a long time. He said it bothered him that it was not fixed. B. Staff interviews (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Pointe Care Center	1655 Yarrow St Lakewood, CO 80214

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An environmental tour was conducted on 9/25/24 at 9:41 a.m. with the maintenance director (MTD) and the above concerns were observed. The MTD said when staff saw something that needed to be fixed or repaired they would send him a text message. He said the facility had an electronic work system to track needed repairs. He said he did not use the system because he wanted to know right away what repairs needed to be done. He said he did not sit by the computer all day and that staff texting him was the best way to reach him. He said all the nurses stations had his phone number and staff knew how to reach him with any problems or concerns. He said he tried not to use the electronic work system. The MTD said he walked through the building at least twice a day every day. He said he did the first walk through first thing in the morning and then he did another walk through in the afternoon around 2:00 p.m. He said he walked through the building by himself as he was the only maintenance person in the building. He said the NHA did his own walk through of the building. The MTD said if he found any issues during the building inspection, he would let the NHA and DON know. He said if he could not fix something right away he would let the NHA know. He said if there was a nursing concern he would let the DON know. The MTD said work orders could take a while to get approved depending on how much it cost to fix the issue. He said anything that cost over 2500 dollars had to be approved by the NHA. He said the approval process could take one week or months. The NHA was interviewed on 9/25/24 at 10:18 a.m. The NHA said he did his own walk through the building once a day. He said the IDT, which consisted of all the department heads (the SSD, the DON, the assistant director of nursing (ADON), the dietary manager (DM), the rehabilitation director, the medical provider (MD) and the MTD) met every morning and did environmental rounds. He said depending on the issues they saw during environmental rounds that needed to be fixed, he would take notes and address the problem or issues right away. The NHA said the MTD was the only person who looked over the building for repairs and maintenance. He said he could reach out to the other communities to help out if needed. He said he was aware of the issues and concerns of the building and was working on getting the building repaired.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on record review, observations and interviews, the facility failed to ensure two (#91 and #66) of two residents out of 45 sample residents were kept free from restraints. Resident #91 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease and dementia. On 8/31/24 Resident #91 was blocking the entrance to the dining room when another resident became upset and struck Resident #91 on the forehead causing a laceration. Resident #91 became upset and was pacing the hallways looking for the other resident. Due to Resident #91's behaviors, the facility staff physically restrained Resident #91 by placing him in the secured unit for the day, instead of providing him with interventions to calm him down after an altercation in which he was hit by another resident. Resident #91, who had Alzheimer's disease, was unable to advocate for himself while he was being restrained in the secured unit. By placing Resident #91 in the secured unit, in an already aggressive state, he began to initiate behaviors with the residents who resided on the secured unit. Additionally, the facility failed to ensure a table was not used to restrain Resident #66. Findings include: I. Facility policy and procedure The Physical Restraint policy and procedure, dated 9/30/23, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:01 pm. It revealed in pertinent part, Physical restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls. II. Resident #91 A. Resident status Resident #91, age 76, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified cataract (clouding of the clear lens of the eye) and sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The 6/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) of three out of 15. He required supervision with all activities of daily living (ADL). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident did not exhibit wandering or exit seeking behaviors during the assessment period and did not reside on the secured unit. B. Observations On 9/23/24 at 3:15 p.m. Resident #91 was sitting on his bed. His call light was laying on the floor between the bed and the wall, inaccessible, with his bed pushed up against the wall. The cord attached to the push button was not connected to the wall, therefore the call light was not functional. There was a call light on the other side of the room that was strung up over the top of what appeared to be a television wall mount and out of reach of Resident #91. Resident #91 did not have a roommate. Resident #91's room was bare, with nothing on the walls. The chest of drawers was missing a drawer, there were no towels near the sink and there was not a trash bag in his trash receptacle. A small box was observed (approximately 12 inches by 8 inches) full of what appeared to be his belongings on the floor, next to the chest of drawers. The bedside table had his dirty black tennis shoes sitting on top of it with the television remote inside his shoe. Cross reference F584: the facility failed to ensure a homelike environment was created for Resident #91 by personalizing his room. Cross reference: F679: the facility failed to meet Resident #91's socialization needs by providing him independent activities in his room and inviting him to group activities according to his preferences. C. Record review The behavioral care plan, initiated and revised on 4/2/25, documented Resident #91 had a history of verbally aggressive behavior due to Alzheimer's disease The interventions included anticipating the resident's needs, providing an opportunity for positive interactions and attention, explaining all procedures and providing a program of activities of the resident's interest and accommodating the resident's needs. The verbal aggression care plan initiated on 9/3/24, documented Resident #91 had the potential to become verbally aggressive due to dementia, ineffective coping skills and poor impulse control. The interventions included providing 15-minute checks as needed, administering medications as ordered, evaluating the resident's coping skills and support system, evaluating the resident's understanding of the situation when agitated, intervening before the agitation escalated, guiding the resident away from sources of distress, engaging the resident calmly in conversation and approaching the resident later if the resident had an aggressive response. -The comprehensive care plan did not reveal documentation that indicated the resident was at risk of exit seeking or elopement. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/3/24 abuse investigation, documented on 8/31/24, revealed Resident #91 was blocking the entrance to the dining room. A male resident asked Resident #91 to move, however Resident #91 did not want to move. The male resident attempted to move Resident #91 out of the way and Resident #91 grabbed the other resident's wrist. The other male resident was able to remove his wrist from Resident #91's grasp and move past Resident #91. As the other resident was leaving, Resident #91 called him a racial slur. The other resident struck Resident #91 on the forehead leaving a laceration and bruising. The 9/1/24 nursing progress note documented at 10:34 a.m. revealed Resident #91 was observed standing in the hallway. He was looking up and down the hallway looking for someone. Resident #91 said, I know how to take care of myself. He better look out, I will find him. Resident #91 then started pacing the hallway and looking into other residents' rooms. The nurse documented that she spoke with the registered nurse (RN) in the facility and asked if Resident #91 could go to the secured unit. The RN agreed and the certified nurse aide (CNA) walked Resident #91 to the secured unit. The 9/2/24 nursing progress note documented Resident #91 returned to unit 200, where he resided, on 9/1/24 at 10:00 p.m. after being in the secured unit since 10:34 a.m. It revealed Resident #91 returned to the unit where he resided due to starting behaviors with the other residents who resided on the secured unit. -The facility failed to provide documentation of Resident #91's time in the secured unit. -The facility kept Resident #91 in the secured unit for 11 hours and 26 minutes. He did not have a bed to lay down in, nor any of his belongings. -The facility did not contact the physician for an order to place the resident in the secured unit, did not obtain consent from the resident's responsible party and did not complete an assessment to determine appropriateness of his placement in the secured unit. -The facility restrained Resident #91 in the secured unit in an attempt to control his behaviors, however the resident continued to display behaviors while on the secured unit. D. Staff interviews The social services director (SSD) and the social services consultant (SSC) were interviewed together on 9/26/24 at 11:08 a.m. The SSD said she was the one who reported the resident to resident altercation that involved Resident #91. She said Resident #91 called another male resident a racial slur and in response, the other resident struck Resident #91 on the forehead. The SSC said the secured unit was considered a restraint. The SSD said she was not aware Resident #91 had been taken to the secured unit after the altercation. The SSC was interviewed again on 9/26/24 at 2:17 p.m. The SSC said it was inappropriate for the facility staff to put Resident #91 on the secured unit. She said the NHA was not aware Resident #91 had been taken to the secured unit after the resident to resident altercation. The SSC said the facility had initiated immediate education to the facility staff regarding restraints, behavioral interventions and the secured unit. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the director of nursing (DON) and the clinical consultant (CC) were interviewed on 9/26/24 at 2:38 p.m. The NHA said it was inappropriate for the facility staff to take Resident #91 to the secured unit when he was having behaviors. He said the facility staff should have used interventions to address Resident #91's behavior, not place him on the secured unit. The NHA said residents must meet a certain criteria of exit seeking behavior and consent had to be obtained in order to place a resident on the secured unit. The NHA and the DON said facility staff should have called them so they could have consulted on how to handle Resident #91's behaviors. 47960 III. Resident #66 A. Resident status Resident #66, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included fracture of the right femur (hip), epilepsy (a chronic brain disorder that causes seizures), unsteadiness on feet and neurocognitive disorder with Lewy bodies (dementia with a build-up of proteins in the brain). The 8/6/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. He was dependent on staff for all ADLs. B. Observations During a continuous observation on 9/25/24, beginning at 9:24 a.m. and ending at 12:49 p.m., the following was observed: At 9:24 a.m. Resident #66 was in the dining room. He was seated in his wheelchair at the dining room table with his wheelchair locked. At 10:32 a.m. the resident was assisted to the television room. At 10:35 a.m. Resident #66 was assisted back to the dining room. The resident was positioned at a table with his wheelchair locked. He remained in the same location with his wheels locked through the lunch service and was assisted to his room at 12:49 p.m. -Resident #66 was positioned in front of the table so he was unable to move freely because he was unable to unlock his wheelchair or self-propel. During a continuous observation on 9/26/24, beginning at 9:05 a.m. and ending at 10:00 a.m., the following was observed: At 9:05 a.m. Resident #66 was in the dining room being assisted with his breakfast. The resident finished his breakfast and remained in the same location at the dining room table with his wheels locked until 10:00 a.m. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:20 p.m. Resident #66 was in the same location as he had been since the morning and the wheelchair was still locked. -Resident #66 was positioned in front of the table so he was unable to move freely because he was unable to unlock his wheelchair or self-propel. C. Resident interview and observation Resident #66 was interviewed on 9/26/24 at 9:12 a.m. Resident #66 said he was able to unlock his wheelchair, however when the resident was asked to demonstrate how he unlocked the wheels on the wheelchair, he was unable to perform the request and made no attempt to move his arms. D. Record review According to the September 2024 CPO the resident did not have a physician's order for restraints. The fall care plan, dated 9/25/24, revealed the resident was at risk for falls. Interventions included anticipating the residents needs and providing frequent checks to ensure the resident was appropriately positioned in the wheelchair. E. Staff interviews The DON was interviewed on 5/17/23 at 2:31 p.m. The DON said residents should not be pushed against a table with their wheels locked if they were unable to unlock them. RN #1 was interviewed on 9/26/24 at 12:20 p.m. RN #1 said Resident #66 had a book for drawing that he liked to use. She said the staff tried to keep him busy and offered toileting regularly. She said the resident had been sitting in the dining room all morning. -Resident #66 did not have an art book or any activities while sitting in the dining room (see observations above). The director of rehabilitation (DOR) was interviewed on 9/26/24 at 1:00 p.m. The DOR said Resident #66 was doing well after his hip fracture but then he had a seizure. She said he returned from the hospital on antiseizure medications and was not able to participate in therapy. The DOR said the therapy staff decided to give the resident more time to adjust to the new medication so they did not pursue therapy the first or second week of his readmission. She said she planned to visit the resident this week (week three) to reevaluate his status going forward. The DOR said when Resident #66 was discharged from therapy on 8/27/24, he could stand, walk, self-propel, lock and unlock the wheels on the wheelchair. She said she was not notified by the nursing staff that the resident was unable to lock or unlock the wheels on his wheelchair. The DOR said residents should never be placed at a table with the wheelchair wheels locked for extended periods unless the resident had the cognitive capacity to ask to do so or unlock the wheels themselves.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on record review and interviews, the facility failed to report a resident to resident altercation that resulted in an injury to the State Survey and Certification Agency in accordance with the state law for one (#91) of one resident out of 45 sample residents. Specifically, the facility failed to report an incident of physical abuse involving Resident #91 to the State Agency in a timely manner. Findings include: I. Facility policy and procedure The Abuse Reporting and Investigating policy and procedure, dated 2/6/23, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:01 p.m. It revealed in pertinent part, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Reporting can be completed verbally or in writing. If any type of abuse, neglect, or misappropriation of property is confirmed, the NHA will be responsible to notify the Health Department Occurrence Reporting website within 2 (two) hours from the time the incident occurred. All other occurrences can be reported the next business day. II. Resident #91 A. Resident status Resident #91, age 76, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified cataract (clouding of the clear lens of the eye and sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The 6/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) of three out of 15. He required supervision with all activities of daily living (ADLs). B. Record review The nursing progress note dated 9/2/24 documented Resident #91 was returned from the secured unit and remained separated from the resident he had an altercation with on a previous shift. It documented Resident #91 was placed on 15-minute checks and that the resident had taken off the dressings from his treatment of the laceration on his head. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interdisciplinary team (IDT) note dated 9/3/24 documented the resident to resident altercation was reviewed. It did not include any additional information. The provider progress note dated 9/5/24 documented the physician was following up with Resident #91 after a recent altercation with another resident. It indicated that Resident #91 was struck in the head. The note documented Resident #91 was unable to recall why he was struck, and denied any behaviors that would cause him to be struck. -A review of Resident #91's electronic medical record (EMR) did not reveal further documentation of the physical altercation between Resident #91 and another resident. The 9/3/24 abuse investigation documented Resident #91 and another resident had a physical altercation on 8/31/24, in which another male resident struck Resident #91 in the head after Resident #91 called the other male resident a racial slur. The altercation resulted in Resident #91 sustaining a laceration to the forehead. -The abuse investigation documented that the physical abuse incident occurred on 8/31/24, but was not reported, nor investigated until 9/3/24, three days after the incident occurred, which resulted in an injury to Resident #91. III. Staff interviews The social services director (SSD) and the social services consultant (SSC) were interviewed together on 9/26/24 at 11:08 a.m. The SSD said she was the one who reported the altercation between Resident #91 and another male resident. She said Resident #91 was in the way of another resident trying to enter the dining room. She said the other resident asked Resident #91 to move, however Resident #91 did not want to move. The SSD said the other male resident attempted to move Resident #91 out of the way, which led to Resident #91 grabbing the other resident's wrist. She said the other resident was able to get his wrist free and move into the dining room. The SSD said as the other male resident was leaving, Resident #91 called the other male resident a racial slur. She said the other male resident then struck Resident #91 on the forehead, which caused a laceration. -On 9/26/24 at 2:17 p.m., the SSC said the incident of physical abuse involving Resident #91 was not reported to the NHA until 9/3/24. She said, once it was reported to the NHA, he began an investigation and reported the incident to the State Agency. She said the incident should have been reported immediately. The NHA and the director of nursing (DON) were interviewed on 9/26/24 at 2:38 p.m. The NHA said the physical altercation between Resident #91 and another resident occurred on a holiday weekend. He said the staff that was working did not notify him until he returned to work on 9/3/24. He said the incident should have been reported immediately after it occurred. The NHA said the incident of physical abuse should have been reported to the State Agency within two hours of the incident because it resulted in an injury. He said any incidents or allegations of abuse that did not result in an injury should be reported within 24 hours of the incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to develop a comprehensive care plan for one (#25) of two residents out of 45 sample residents for services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to ensure the comprehensive care plan addressed Resident #25's use of hearing aids and compression socks. Findings include: I. Resident #25 A. Resident status Resident #25, age 74, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (a common lung disease causing breathing problems), Alzheimer's disease, type 2 diabetes mellitus, hypertensive chronic kidney disease and major depressive disorder. The 9/3/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. She was dependent on staff for transfers, bathing and putting on footwear. She used a wheelchair for mobility and required assistance to propel her wheelchair. The assessment indicated Resident #25 had adequate hearing utilizing hearing aids. B. Resident interview and observations On 9/23/24 at 1:30 p.m. Resident #25 was in her room. Resident #25 was not wearing hearing aids or compression socks. Resident #25 said the certified nurse aide (CNA) got her dressed this morning (9/23/24) but did not put her hearing aids in her ears or put her compression socks on her feet. -Resident #25's hearing aides were observed laying on her dresser. Resident #25 pointed to a sign on her wall which had instructions for facility staff to put her hearing aids in and her compression socks on every morning. On 9/24/24 at 2:00 p.m. Resident #25 was not wearing compression socks. She said the facility staff told her all of her compression socks were in the laundry. C. Record review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The communication care plan, initiated 12/19/23 and revised 5/22/24, indicated Resident #25 had the potential for a communication problem related to cognitive deficit. Interventions included allowing adequate time to respond, repeating as necessary, not rushing, requesting clarification from the resident to ensure understanding, facing the resident when speaking, maintaining eye contact and reducing environmental noise. -The communication care plan did not indicate Resident #25 wore hearing aids. The activities of daily living (ADL) care plan, initiated 12/7/23 and revised 3/19/24, indicated Resident #25 had a self-care deficit related to dementia, impaired balance, limited mobility and pain. The care plan indicated Resident #25 required assistance with mobility using a wheelchair, assistance with dressing and transfers -The ADL care plan did not include Resident #25 wore compression socks or needed assistance putting on compression socks. -The ADL care plan did not indicate Resident #25 wore hearing aids or needed assistance putting in hearing aids. The activities care plan, initiated 12/13/23 and revised 12/28/23, indicated Resident #25 enjoyed both group and independent leisure activities. Interventions included staff providing assistance to and from activities of interest and making sure the resident's hearing aides were in and turned on during activities. -There was no documentation in Resident #25's EMR to indicate that Resident #25 was receiving assistance putting in her hearing aids or putting on her compression socks. II. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 9/26/24 at 9:00 a.m. CNA #5 said resident preferences for each resident were listed on the resident's Kardex (nursing tool that summarizes resident information and directs care). She said the CNAs should follow the care and preferences indicated on the Kardex. The director of nursing (DON) was interviewed 9/26/24 at 2:38 p.m. The DON said the comprehensive care plan should reflect the preferences and use of ancillary devices for the resident. He said items documented on the comprehensive care plan were pulled to the Kardex to inform the CNAs how to provide care to each resident. The DON said Resident #25 required assistance with putting her hearing aids in her ears in the morning, taking them out at night and donning and doffing (putting on and taking off) her compression socks. He said Resident #25's use of hearing aids and compression socks should be documented on the comprehensive care plan and the Kardex. The DON said said he would update Resident #25's comprehensive care plan to include her use of hearing aids and compression socks.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure activities designed to support residents' physical, mental and psychosocial well-being were provided for three (#91, #96 and #301) of three residents outside of the secured unit and all residents on the secured unit out of 45 sample residents. Specifically, the facility failed to: -Ensure Resident #91, Resident #96 and Resident #301 were provided with meaningful activities that promoted their mental and psychosocial well-being; and, -Ensure residents on the secure unit were provided with meaningful activities that promoted their mental and psychosocial well-being. Findings include: I. Facility policy and procedure The Activities Schedule policy, revised on 3/14/23, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:07 p.m. The policy read in pertinent part, The community will provide daily activities that not only meet the requirements of state and federal guidelines, but also the interests, preferences, hobbies and the culture of the participants and community. Daily activities include community-sponsored group and individualized activities, in addition to assistance with independent daily activities. Activities will be designed to meet and support the participant's physical, mental, intellectual and psycho-social well-being. Activities will create opportunities for each participant to have a meaningful life by supporting their domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning). Activities will be designed to meet participants' best ability to function, incorporating their strengths and abilities. Activities will encourage both independence and community interaction, including the use and support/interaction of volunteers where appropriate. II. Resident #91 A. Resident status (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #91, age 76, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified cataract (clouding of the clear lens of the eye and sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The 6/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He required supervision with all activities of daily living (ADL). B. Observations On 9/24/24 during a continuous observation, beginning at 2:04 p.m. and ending at 4:27 p.m., Resident #91 was in his room and the following observations were made: At 2:10 p.m., Resident #91 opened his door and peered out of his room. Resident #91 appeared confused. He went back into his room and closed the door. At 4:17 p.m. Resident #91 exited his room and stood in the hallway. An unidentified certified nurse aide (CNA) stopped him and fixed his sleeve. Resident #91 was looking for the dinner menu, which was in the unidentified CNA's hand. The CNA hung the menu back up on the wall. At 4:27 p.m. Resident #91 exited his room and walked down the hallway toward the dining room. -During the above continuous observation, the activities department was conducting group activities of fall crafts and hosting a music group. Resident #91 was not invited to any group activities and did not receive any staff interaction other than when he exited his room and stood in the hallway looking for the dinner menu. On 9/25/24 during a continuous observation, beginning at 1:46 p.m. and ending at 4:10 p.m. Resident #91 was in his room and the following observations were made: At 1:46 p.m. Resident #91 closed his door. At 3:16 p.m. an unidentified nurse brought Resident #91 a labeled snack and then closed his door. -Between 1:46 p.m. and 3:16 p.m. no staff members entered Resident #91's room. At 3:51 p.m. the same unidentified nurse entered Resident #91's room and administered the resident's medications. The nurse left the door open after exiting the resident's room. At 3:52 p.m. Resident #91 was sitting up in bed, staring out the window. At 3:53 p.m. Resident #91 got up and closed his door. -During the above continuous observation, group activities such as games in the lobby, music, and color association were being conducted. Resident #91 was not invited to the group activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The activities care plan, revised on 4/4/24, revealed Resident #91 enjoyed collecting rocks, minerals and jewelry. He enjoyed listening to rock and roll music, painting, sketching and creating art pieces. The interventions included providing a monthly calendar as a reminder of all activities, providing invites and reminders to join group activities and providing independent leisure supplies for the resident. The activities progress note dated 9/3/24 documented that Resident #91 refused the one-to-one activity. -The type of one-to-one activity offered to the resident was not documented. -There was no additional activity documentation available for Resident #91. The September 2024 activities schedule included many activities that were of interest, according to the care plan, to Resident #91, such as music groups, watercolor painting, art with a special host, sip and paint, canvas painting and coloring. -However, observations during the survey revealed Resident #91 was not invited to attend group activities (see observations above). D. Staff interviews The activities director (AD) was interviewed on 9/26/24 at 10:00 a.m. The AD said each resident should be invited to all group activities. She said she was not sure if Resident #91 attended activities. She said she was not sure what type of activities Resident #91 would be interested in or attend. She said Resident #91 was not currently on a one-to-one activity program. The social services director (SSD) and the social services consultant (SSC) were interviewed on 9/26/24 at 11:08 a.m. The SSD said Resident #91 would come down to her office and talk with her and the NHA). She said Resident #91 enjoyed painting. She said she was not aware if Resident #91 was invited to or attended group activities. The NHA and the director of nursing (DON) were interviewed on 9/26/24 at 2:38 p.m. The NHA said each resident should be invited to group activities. He said it was the responsibility of every staff member to invite residents to group activities. The NHA said Resident #91 liked to talk about his service in the military. He said staff probably did not check on Resident #91 since he was ambulatory and felt like the resident was self-sufficient. He said even though Resident #91 was ambulatory and did not require a lot of assistance with ADLs, he still deserved social interaction throughout the day. The NHA said he would meet with the facility staff to ensure Resident #91 was invited to group activities and he was provided with social interaction throughout the day. He said he would identify other residents that might have the same concern and he would update their comprehensive care plans. 50853 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident #96 A. Resident status Resident #96, age 82, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included Alzheimer's disease, unspecified dementia with anxiety, hypertension and liver disease. The 7/29/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. She required substantial to maximal assistance with transfers and personal hygiene. She used a wheelchair for mobility and depended on staff to propel the wheelchair. B. Observations On 9/23/24 the following observations were made: At 11:00 a.m. Resident #96 was sitting at the counter at the nurses station in the 300 hall. She had an Ensure supplement in front of her but she did not have any activity materials in front of her. At 12:00 p.m. Resident #96 was eating lunch at the nurses station. At 1:17 p.m. Resident #96 was sitting at the nurses station. A live music activity had started in the main lounge down the hall from the nurses station at 1:00 p.m. Resident #96 could hear the music from the nurses station and she was moving to the music and smiling. -Resident #96 was not assisted by staff to attend the music program in the lounge. At 2:42 p.m. Resident #96 was sitting at the nurses station. There were no activity materials in front of her. She did not have a drink or a snack. At 3:38 p.m. Resident #96 was sitting at the nurses station with an empty water cup in front of her. The activity calendar indicated a canvas painting activity had started at 3:30 p.m. -Resident #96 was not assisted to attend the painting activity. On 9/24/24 the following observations were made: At 9:29 a.m. Resident #96 was lying in bed. She was awake and moving around. The activity calendar indicated there was a daily gathering activity scheduled at 9:30 a.m. and rosary prayers at 10:00 a.m. -Resident #91 was not assisted to attend either activity. At 11:57 a.m. Resident #96 was sitting in her wheelchair in her room. There were no meaningful activities provided for the resident to engage in and there was no music playing in the resident's room. A certified nurse aide brought her out to the nurses station and put her lunch on the counter in front of her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 during a continuous observation, beginning at 1:53 p.m. and ending at 5:37 p.m., the following observations were made: At 1:53 p.m. Resident #96 was sitting behind the nurses station. A Bingo activity was scheduled to begin at 2:00 p.m. -Resident #96 was not invited to attend Bingo. At 2:06 p.m. Resident #96 remained sitting behind the nurses station touching and twisting another resident's oxygen tubing who was sitting next to her. No activity supplies were provided to her. At 2:15 p.m. Resident #96 remained behind the nurses station. An unidentified CNA was charting at the computer near Resident #96. The CNA talked briefly to the resident but did not offer her a snack, drink or activity supplies. At 2:24 p.m. Resident #96 was speaking in Spanish to herself. A radio near her was playing country music. At 2:32 p.m. a CNA pushed Resident #96 in her wheelchair to her room. There were no other activities scheduled on the activity calendar for the afternoon. At 2:37 p.m. the CNA left Resident #96's room. The resident was lying in bed. -There was no music playing in the resident's room. At 3:39 p.m. Resident #96 remained in bed. -There was no music playing in the resident's room. At 4:59 p.m. Resident #96 remained in bed. She was awake and moving her legs. -There was no music playing in the resident's room. At 5:37 p.m. Resident #96 remained in bed. -There was no music playing in the resident's room. On 9/25/24 during a continuous observation, beginning at 8:59 a.m. and ending at 12:19 p.m. At 8:59 a.m. Resident #96 was lying in bed. She was awake. -There was no music playing in the resident's room. At 9:16 a.m. the activities assistant (AA) went into room [ROOM NUMBER], across the hall from Resident #96. She was passing out the daily chronicle. At 9:17 a.m. the AA walked to the door of Resident #96's room but registered nurse (RN) #3 was entering the room with medication for the resident. The AA did not go into the resident's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:20 a.m. the AA walked back down the hall and passed by Resident #96's room without stopping. There was a soup making activity scheduled at 10:00 a.m., however, Resident #96 was not invited to the activity. At 10:25 a.m. CNA #6 brought Resident #96 out of her room in her wheelchair and placed her behind the nurses station at the counter. At 10:55 a.m. Resident #96 continued sitting at the nurses station. No staff were interacting with her and the resident did not have any meaningful activities in front of her. At 11:07 a.m. CNA #5 was charting behind the nurses station next to Resident #96 but did not interact with her. Resident #96 was not provided with any activity supplies. At 12:04 p.m. Resident #96 was sitting at the nurses station with her eyes closed. She did not have any meaningful activities in front of her. -At 12:14 p.m. room trays were delivered to the 300 hall. Resident #96 was sitting behind the nurses station. Another resident, who was sitting beside her, was fiddling with his oxygen tubing. The director of rehabilitation (DOR) addressed the other resident and offered to provide something for him to fiddle with. The DOR left and returned with a jar of beads and other items for him. -The DOR did not address Resident #96 or offer her any activity supplies. At 12:19 p.m. lunch was delivered to Resident #96 and placed on the nurses station counter in front of her. On 9/25/24, the following additional observations were made: At 1:26 p.m. Resident #96 was sitting at the nurses station with her eyes closed. She did not have any meaningful activities in front of her. At 1:36 p.m. CNA #5 took Resident #96 to her room. When CNA #5 left the room, the resident was lying in bed. A music program was scheduled to begin at 2:00 p.m., however, Resident #96 was not able to attend because CNA #5 had put her in bed. At 2:45 p.m. Resident #96 was in bed. A live music activity was scheduled to begin at 3:00 p.m., however, staff did not get the resident out of bed so she could attend the program. At 4:50 p.m. Resident #96 was sitting at the nurses station. An unidentified CNA was sitting behind her charting but the CNA was not interacting with the resident. On 9/26/24 at 8:55 a.m. Resident #96 was in bed, awake. A daily gathering activity was scheduled to begin at 9:30 a.m., however, staff did not get the resident out of bed so she could attend the activity. At 10:56 a.m. Resident #96 was sitting at the nurses station by herself, talking to herself. There were no activity supplies provided to her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:57 p.m. Resident #96 was sitting at the nurses station with a full lunch plate in front of her. She was not eating and staff were not present. At 1:03 p.m. Resident #96 dropped her full plate of food on the floor. C. Record review The activities care plan, initiated 5/3/24 and updated 8/2/24, indicated Resident #96 identified her religion as Catholic. She enjoyed playing bingo, spending time outdoors, being social, dancing, listening to music, and cooking. Interventions included activities staff inviting and encouraging her to attend activities and activities staff offering independent leisure supplies. The care plan indicated Resident #96 used a manual wheelchair and activities staff would provide assistance to and from activities. Review of Resident #96's activity documentation on 9/24/24 and 9/25/24 revealed the following: On 9/24/24 at 2:29 p.m. the activity documentation indicated Resident #96 refused creative, cognitive and therapeutic activities. -However, continuous observation on 9/24/24 from 1:53 p.m. to 5:37 p.m. revealed the resident was sitting at the nurses station and lying in bed. She was not approached by activities staff to attend activities during that time (see observations above). On 9/25/24 at 10:48 a.m. the activity documentation indicated Resident #96 refused to attend a group activity and was active with independent leisure. -However, continuous observation on 9/25/24 from 8:59 a.m. to 12:19 p.m. revealed activity staff did not enter her room on the morning of 9/25/24 to invite her to activities or observe her participating in independent leisure activities. Resident #96 was still in bed at that time (see observations above). IV. Resident #301 A. Resident status Resident #301, age 88, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included fracture of left femur (the large bone in upper leg), unspecified dementia, muscle weakness, dysphagia (difficulty swallowing), hypertension (high blood pressure) and anxiety disorder. The 9/16/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. She required partial to moderate assistance with transfers and personal hygiene. She used a wheelchair for mobility and depended on staff to propel the wheelchair. B. Observations On 9/23/24 at 1:20 p.m. Resident #301 was sitting at the counter at the nurses station on the 300 hall eating ice cream. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:37 p.m. Resident #301 was sitting at the nurses station with an empty Ensure supplement carton. -She did not have any meaningful activities in front of her. At 4:15 p.m. Resident #301 was sitting at the nurses station. She had no meaningful activities in front of her. She did not attend the music program that was held in the common area. On 9/24/24 at 9:28 a.m. Resident #301 was in bed with her eyes closed. At 11:05 a.m. Resident #301 was in bed, awake. -There was no music playing in the resident's room. On 9/24/24 during a continuous observation, beginning at 1:53 p.m. and ending at 3:40 p.m., the following observations were made: At 1:53 p.m. Resident #301 was sitting behind the nurses station, slumped over in her wheelchair. Bingo was scheduled to begin at 2:00 p.m. -She did not have any meaningful activities in front of her and staff did not invite her to attend Bingo. At 2:13 p.m. CNA #5 took Resident #301 into a bathroom near the nurses station. At 2:16 p.m. CNA #5 brought the resident back to the nurses station and left her at the counter. -CNA #5 did not provide Resident #301 with any meaningful activities. At 2:25 p.m. Resident #301 had three packages of hand wipes and seemed to be reading the labels. CNA #5 moved her over so a male resident could sit at the nurses desk. At 2:32 p.m. CNA #5 took Resident #301 into her room. At 2:36 p.m. CNA #5 left the resident's room after putting Resident #301 in bed. -There was no music playing in the resident's room. At 3:40 p.m. Resident #301 continued lying in bed. -There was no music playing in the resident's room. On 9/24/24 the following additional observations were made: At 4:32 p.m. Resident #301 was sitting at the nurses station with a cup of coffee. At 5:00 p.m. the resident continued sitting at the nurses station. She had no meaningful activities in front of her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 5:35 p.m. Resident #301 was sitting at the nurses station. Room trays had not been delivered and the resident continued to have no meaningful activities in front of her. On 9/25/24 during a continuous observation, beginning at 8:59 a.m. and ending at 10:25 a.m., the following observations were made: At 8:59 a.m. Resident #301 was in bed with her eyes closed. -There was no music playing in the resident's room. At 9:16 a.m. the AA went into room [ROOM NUMBER], across the hall from Resident #301. She was passing out the daily chronicle. At 9:17 a.m. the AA walked to the door of Resident #301's room but registered nurse (RN) #3 was entering the room with medication. The AA did not go into the room. At 9:20 a.m. the AA walked back down the hall and passed by Resident #301's room without stopping. There was a soup making activity scheduled at 10:00 a.m., however, Resident #301 was not invited to the activity. At 10:05 a.m. an unknown staff person entered Resident #301's room. At 10:09 a.m. the staff person came out into hall and told CNA #5 that Resident #301 did not want to get up. CNA #5 said she would help and entered the resident room. At 10:25 a.m. CNA #5 brought Resident #301 out of her room in her wheelchair and pushed her down the hall toward the dining room and common area. On 9/25/24, the following additional observations were made: At 2:01 p.m. Resident #301 was sitting in the dining room at a table with two other residents. Resident #301 was looking at meal tray cards for other residents. A music program was starting in the common area. At 2:31 p.m. Resident #301 remained sitting in the dining room at the same table with another resident. She was still looking at meal tray cards for other residents. Staff had not assisted her to the music program. At 3:21 p.m. Resident #301 was sitting at the nurses station with an empty glass in front of her and no meaningful activities. At 3:59 p.m. Resident #301 was sitting at the nurses station. There were no meaningful activities on the counter in front of her. At 4:50 p.m. Resident #301 was sitting at the nurses station. She was messing with the shirt of a male resident sitting next to her, trying to tie it on his wheelchair brake handle. A CNA behind her intervened and told her she could not tie the other resident's shirt on the brake handle. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The CNA did not provide Resident #301 with any activity supplies or move her away from the other resident. On 9/26/24 at 8:54 a.m. Resident #301 was in bed with her eyes closed. A daily gathering activity was scheduled at 9:30 a.m., however, staff did not get the resident out of bed so she could attend the activity. At 11:38 a.m. Resident #301 remained in bed and was awake. -There was no music playing in the resident's room. C. Record review The activities care plan, initiated 9/18/24 and updated 9/20/24, indicated Resident #301 enjoyed watching her favorite television programs throughout the day, keeping up with the news, listening to music, playing bingo on occasion, and exercising on occasion. Care plan interventions included staff reminding and encouraging her to attend group activities of her interest and choice and providing assistance to and from activities. Review of Resident #301's activity documentation on 9/24/24 revealed the following: On 9/24/24 at 2:29 p.m. the activity documentation indicated Resident #301 refused creative, cognitive and therapeutic activities. -However, continuous observation on 9/24/24 from 1:53 p.m. to 5:35 p.m. revealed the resident was sitting at the nurses station and lying in bed. She was not approached by activities staff to attend activities during that time (see observations above). V. Staff interviews CNA #5 was interviewed on 9/25/24 at 2:50 p.m. CNA #5 said the activity staff invited residents to activities. She said the CNAs and nurses reminded them. CNA #5 said Resident #96 did not attend activities because she tried to wheel away or got up and walked unsafely. CNA #5 said there was an activity box at the nurses station they could give to residents. She said sometimes she brought Spanish music for Resident #96 to listen to. CNA #5 said resident #301 did not go to many activities. She said the resident did not stay focused and activity staff brought her right back. The AD was interviewed on 9/26/24 at 2:23 p.m. The AD said activity preferences should be in the residents' care plans. She said staff should invite residents to activities daily. The AD said Resident #96 had attended a couple of group activities and she asked the activity staff to bring her to groups. She said staff could offer Resident #96 a busy apron or some coloring when she was sitting at the nurses station. The AD said she was planning to start offering one-to-one visits with Resident #96 because she spoke Spanish. The AD said it was important for residents to have some meaningful activity daily. She said if staff were documenting a resident refused an activity she would have expected them to invite them personally. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 9/26/24 at 2:38 p.m. The NHA said staff should be offering activity supplies for residents who were sitting at the nurses station. He said the residents' electronic medical records (EMR) needed to reflect residents' preferences and staff should document what they were doing and trying for activities for residents. The NHA said residents should be provided meaningful activities even when sitting at the nurses station. The NHA said all staff should invite residents to activities, not just the activity staff. The NHA said if activity staff documented a resident refused an activity then they should have asked them, not just document it was refused. The NHA said the facility would be changing their approach to activities, involving the interdisciplinary team (IDT) and creating a realistic activity calendar. 47960 VI. Secure unit residents A. Observations On 9/25/24 at 4:15 p.m. four residents in the secure unit were hovering by the medication cart, two residents were sitting at dining room tables and two residents were walking around the dining room. A resident picked up the nurse's computer from the table behind her. The resident was looking at the nurse's papers. -There were no other staff members in the dining room and eight residents in the area were without meaningful activity stimulation. Four residents were sitting in the living room by the exit doors without meaningful activity stimulation. On 9/26/24 at 9:19 a.m., the AA wheeled one resident from the dining room to the living room to read the daily news. -Nine residents remained in the dining room without meaningful activity stimulation and only two of the residents were able to self-propel their wheelchairs. On 9/26/24 at 9:35 a.m. the AA was sitting in the living room holding the remote control for the television. There were five residents in the room with her while she was finding something on the television to watch. On 9/26/24 at 9:41 a.m. Resident #43 was in her wheelchair in the hallway. She said, What are we doing today? A whole lot of nothing? Well that's new. Resident #43 continued to wheel down the hallway. -No staff members acknowledged Resident #43. B. Staff interviews (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AA was interviewed on 9/26/24 at 9:35 a.m. The AA said she had only been in the activities department since the middle of August 2024. She said the residents on the secured unit liked to listen to music and watch television. She said sometimes the residents went outside if they felt like it but she identified the wrong location for outdoor time with the residents on the secure unit. The AD was interviewed on 9/26/24 at 10:00 a.m. The AD said she had only been working in her role for a couple of months. The AD said she created the activity calendar. She said she tried to oversee the activities in the secure unit at least once per day and it was her expectation that residents would go outside three to four times a week. The AD said the activities department was short staffed and currently had one position open but she said she encouraged her activities staff to rotate through the facility and follow the activity calendar as best as they could. She said when the residents on the secure unit were engaged in activities it helped with their mood and when residents were bored, their behaviors could increase.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent pressure injuries from occurring or to prevent reoccurrence of pressure injuries for one (#20) of two residents reviewed out of 45 sample residents. Specifically, the facility failed to ensure physician recommendations for heel protection boots and a wheelchair cushion were implemented for Resident #20, who had a deep tissue pressure injury on her right heel. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 10/1/24, 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 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 (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 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. For individuals with a Category/Stage III or greater heel pressure injury, elevate the heels using a device specifically designed for heel suspension, offloading the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon and the popliteal vein. Once a pressure injury develops, pressure relief on the heel is needed to promote perfusion and healing. Pressure on Category/Stage III, IV, and unstageable heel pressure injuries and deep tissue pressure injuries of the heel should be completely offloaded as much as possible. II. Resident #20 A. Resident status Resident #20, age 86, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included a fracture of the right femur (large bone in the upper leg), cerebral infarction (stroke), dysphagia (difficulty swallowing), muscle weakness and Parkinsonism (a general term for neurodegenerative diseases that cause similar motor symptoms, such as rigidity, tremors, and slow movement). The 7/16/24 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 required substantial to maximal assistance with transfers and used a wheelchair for mobility. The MDS revealed The assessment indicated Resident #20 was at risk for developing a pressure injury and was using a pressure reducing device for her bed and chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 9/23/24 at 3:54 p.m. Resident #20 was sitting in her wheelchair in her room. There was no cushion in her wheelchair. She had tennis shoes on both feet. A sign was posted on the wall near her bed stating she was to wear a heel protection boot on her right foot. The sign did not indicate when the boot was to be worn. Resident #20 said she had a sore on her right heel. -However, according to the resident's care plan she was to have heel protection boots on both feet (see record review below). On 9/24/24 the following observations were made: -At 11:08 a.m. Resident #20 was sitting in her wheelchair in the dining room. She was wearing tennis shoes on both feet and did not have a cushion in her wheelchair. At 1:55 p.m. Resident #20 was lying in bed on her back. She did not have a heel protection boot on her right foot. At 3:30 p.m. Resident #20 was sitting in her wheelchair with tennis shoes on both feet. She did not have a cushion in her wheelchair. Resident #20 said she used to have a cushion in her wheelchair but she did not know what happened to it. She said her wheelchair seat was hard and became uncomfortable after a while. At 5:00 p.m. Resident #20 was in the dining room sitting in her wheelchair. She had tennis shoes on both feet and no cushion in her wheelchair. On 9/25/24 the following observations were made: -At 9:34 a.m. Resident #20 was sitting in her wheelchair with tennis shoes on both feet. There was no cushion in her wheelchair. At 10:41 a.m. Resident #20 was sitting in the dining room in her wheelchair. There was no cushion in the wheelchair. She had tennis shoes on both feet. At 12:24 p.m. Resident #20 was lying in bed. She had a heel protection boot on her right foot. -However, according to the resident's care plan she was to have heel protection boots on both feet (see record review below). On 9/26/24 at 1:07 p.m. Resident #20 was observed receiving wound care from registered nurse (RN) #2. There was a very small scab present on the bottom of Resident #20's right heel. -Multiple observations during the survey (from 9/23/24 to 9/26/24) revealed Resident #20 did not have a cushion in her wheelchair and was not wearing heel protection boots on both of her feet, however, according to the resident's care plan, she was to have a wheelchair cushion and heel protection boots on both feet (see record review below). C. Record review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 7/16/24 Braden Scale Assessment (a tool used to determine risk for pressure injury) indicated Resident #20 was at risk for developing pressure injuries. Her risk factors included limited mobility, inadequate nutrition and shearing (occurs when forces are applied to body tissues or parts that cause the tissues to move in opposite directions). The pressure injury care plan, initiated 5/21/24 and revised 9/10/24, included the intervention of a pressure relieving wheelchair cushion and pressure relieving devices or adaptive equipment when appropriate to potential pressure areas. The skin integrity care plan, initiated 7/22/24 and revised 8/6/24, included the intervention of foam boots (heel protection boots) to bilateral feet as tolerated. The 9/19/24 wound physician progress note documented Resident #20 had a right heel deep tissue pressure injury which was acquired on 7/30/24 and was not healed. Wound measurements were 0.4 centimeters (cm) length by 0.2 cm width with no measurable depth. The wound bed had 100% epithelialization (new cells covering the wound in the final stage of healing). Interventions included ensuring a seat or wheelchair cushion was in place and floating heels while in bed. Review of the September 2024 CPO revealed Resident #20 had a physician's order to apply a right heel protection boot while in bed or in her wheelchair every shift, ordered 7/19/24. -However, according to the resident's care plan she was to have heel protection boots on both feet (see care plan above). Review of the September 2024 medication administration record (MAR) revealed nurses were documenting every shift that Resident #20 was wearing the heel protection boot on her right foot while in bed and in her wheelchair. -However, multiple observations during the survey revealed the resident was wearing tennis shoes while she was in her wheelchair (see observations above). III. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 9/25/24 at 2:30 p.m. CNA #5 said if a resident was at risk for pressure ulcers the staff could ask for an air mattress for the resident. She said the staff could apply barrier cream, change the residents frequently, make sure the residents' skin was clean and dry and reposition them as needed. CNA #5 said Resident #20 had a wound on her bottom but it was healed. She said the resident had a wound on her right heel that occurred after her hip fracture. CNA #5 said she thought the wound on the resident's heel was healed also but she still was supposed to wear the heel protection boot when she was in bed. CNA #5 said the therapy department provided wheelchair cushions and she thought Resident #20 had a cushion in her wheelchair. RN #3 was interviewed on 9/25/24 at 9:34 a.m. RN #3 said Resident #20 usually wore the boot on her right foot when she was in bed for pressure relief. RN #3 pointed out the boot on the floor near the head of the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 9/26/24 1:07 p.m. while providing wound care to Resident #20. She said the wound on the resident's right heel was much larger initially but was almost healed. She said the wound physician visited Resident #20 weekly. The director of nursing (DON) was interviewed on 9/26/24 at 2:38 p.m. The DON said preventative measures for pressure ulcers could include air mattresses, foam boots to float the heels, repositioning and nutrition interventions. The DON said a wheelchair should have a pressure reduction cushion in it. He said Resident #20 was refusing to wear the boot on her right foot and the physician discontinued it on 9/25/24 (during the survey). The DON said he made a progress note on 9/25/24 (during the survey) reflecting the resident's preferences. The DON said nurses should have been documenting Resident #20's refusal to wear the heel protection boot. The DON said he would provide education to the staff. -However, there was no documentation in Resident #20's electronic medical record (EMR) to indicate the resident refused to wear the heel protection boots prior to 9/25/24, during the survey, when the DON entered his progress note.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on record review and interviews, the facility failed to ensure that one (#8) of one out of 45 sample residents with limited range of motion received appropriate treatment and services. Specifically, the facility failed to ensure that Resident #8 was placed on a maintenance program after therapy treatment had been discontinued. Findings include: I. Facility policy and procedure The Restorative Nursing Services policy and procedure, undated, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:01 p.m. It revealed in pertinent part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals may include, but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence and self-esteem; and participating in the development and implementation of his/her plan of care. II. Resident #8 A. Resident status Resident #8, age 88, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included chronic respiratory failure with hypoxia (when the blood does not have enough oxygen), chronic obstructive pulmonary disease (lung disease that blocks airflow making it hard to breathe), bipolar disorder (mental disorder that causes shifts in mood and behavior) and Alzhimer's disease. The 5/6/24 minimum data set (MDS) assessment revealed that 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 all activities of daily living (ADL), including bed mobility, dressing, incontinence care and personal hygiene. It indicated Resident #8 was on a prescribed physical therapy program from 5/13/24 to 6/11/24. B. Resident interview (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 was interviewed on 9/23/24 at 1:29 p.m. Resident #8 said she had received physical therapy a couple months ago. She said the physical therapy had stopped and she did not know why. She said she wanted to be able to do some ADLs by herself, instead of relying on the facility staff. She said her goal was to be able to sit up in bed by herself and get into the wheelchair. Resident #8 said she would love to be able to walk, but was aware that was a lofty goal. She said the facility did not put her on a maintenance program following the discontinuation of physical therapy. She said the physical therapist gave her a sheet of exercises to do, but never instructed the facility staff to assist her. She said the exercises were difficult to do on her own. Resident #8 said she would have liked to have been put on a maintenance program, but was never asked. C. Record review The ADL care plan, revised 5/16/24, documented Resident #8 had an ADL deficit due to her impaired balance. The documented goal was to ensure the resident maintained her current level and did not decline in her need for ADL assistance. The interventions included discussing with the resident and her family any concerns related to loss the resident's of independence, encouraging Resident #8 to participate to her fullest extent with each interaction and monitoring and documenting any changes or potential for improvement. The limited physical mobility care plan, revised 8/2/24, documented Resident #8 had limited mobility and required staff assistance. The interventions included providing gentle range of motion as tolerated with her daily care and physical therapy and occupational therapy referrals as ordered. The 6/13/24 physical therapy discharge summary documented Resident #8 made improvements with her bed mobility going from dependent to maximal assistance. The recommendations indicated Resident #8 should continue with a home exercise program to maintain and improve functional performance and safety. It indicated that Resident #8's prognosis would be good with consistent staff follow-through, however the physical therapist documented that a restorative program was not indicated at that time. A review of Resident #8's medical record did not reveal documentation that a maintenance program had ever been discussed or offered to Resident #8. III. Staff interviews The director of rehabilitation (DOR) was interviewed on 9/26/24 at 12:53 p.m. The DOR said when physical, occupational or speech therapy was discontinued, the facility typically placed the resident on a restorative program. She said the restorative program was a maintenance program that was used to ensure the resident maintained their current level of ADL status and did not decline. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure the residents environment remained as free of accident hazards as possible and ensured residents received adequate supervision and assistance to prevent accidents for one (#20) of five residents reviewed for accidents/hazards out of 45 sample residents. Specifically, the facility failed to: -Ensure staff consistently implemented fall interventions for Resident #20, which included placing the resident's call light within reach when she was in her room. Findings include: I. Facility policy and procedure The Fall Management policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:07p.m. It read in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. The following interventions may be considered after identification of root cause: assess the environment and make appropriate changes (bed in lowest position, placement of furniture, lighting, personal items within reach, non-slip footwear, night light, walker, wheelchair within reach if applicable). The call light and fluids should be within reach of the resident. Document in (the electronic medical record) the resident's response to interventions and revise interventions if they are not successful. II. Resident #20 A. Resident status Resident #20, age 86, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included fracture of the right femur (large bone in the upper leg), cerebral infarction (stroke), dysphagia (difficulty swallowing), muscle weakness and Parkinsonism (a general term for neurodegenerative diseases that cause similar motor symptoms, such as rigidity, tremors, and slow movement). The 7/16/24 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 required substantial to maximal assistance with transfers and used a wheelchair for mobility. B. Observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 9:12 a.m. Resident #20 was sitting in her wheelchair in her room. The call light was clipped on the pillow at the head of the bed behind her. The resident was sitting towards the foot of the bed with the bedside table in front of her and could not reach the call light. On 9/25/24 at 12:24 p.m. Resident #20 was lying in bed. Her call light was clipped to the left side of her pillow where she could not see it. She said she did not know where it was. On 9/26/24 at 8:51 a.m. Resident #20 was sitting in her room in her wheelchair asleep. Her call light was laying on the bed in front of her, not easily reachable. On 9/26/24 at 2:40 p.m. Resident #20 was sitting in her wheelchair in her room. Her call light was clipped to her pillow behind her out of her reach. The director of nursing (DON) went into the resident's room and moved the call light right next to the resident. Resident #20 demonstrated she could reach it and demonstrated she could push the call light after the DON moved it closer to her. C. Record review The fall risk assessment, dated 9/5/24, indicated Resident #20 was at high risk for falls because she had three or more falls in the past 90 days, she took three or more high risk medications and had three or more high risk diagnoses. Review of the resident's electronic medical record (EMR) from 6/1/24 through 9/25/24 revealed Resident #20 had eight falls during that time frame with the following interventions implemented: On 6/10/24 the resident attempted to self-transfer and fell . Interventions implemented were educating her to lock her wheelchair brakes and reminding her to use her call light for assistance. On 7/2/24 the resident attempted to self-transfer with her wheelchair brakes unlocked and fell . Interventions implemented were educating and encouraging her to lock her wheelchair brakes prior to transfers. She was educated to call for assistance with transfers. Resident #20 sustained a left hip fracture from the fall. On 7/18/24 the resident had removed her socks, attempted to self-transfer and fell . Interventions implemented were providing her with non-skid socks and reminding her to keep them on. On 7/18/24 the resident attempted to self-transfer and fell . Interventions implemented were to place Resident #20 within staff eyesight at the nurse's station (as she allowed). Staff should talk with her, offer snacks/fluids or activity supplies. On 7/22/24 the resident attempted to self-transfer, slid out of her wheelchair and fell . Interventions implemented were to encourage the resident to sit at the nurses station when out of bed. Dycem (a sticky pad to prevent slipping) was placed in her wheelchair. On 9/4/24 the resident attempted to self-transfer and fell . Interventions were to re-enforce the use of the call light, encourage Resident #20 to call for assistance and offer hipsters to protect her from hip injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/8/24 the resident attempted to self-transfer to the toilet and fell . Interventions were to remind Resident #20 to request staff assistance with transfers and for staff to check and change her every four hours and as needed. The fall care plan, initiated on 5/10/24 and revised on 9/10/24. Additional interventions to the ones listed after each fall above, included ensuring the resident's call light was within reach and encouraging/reminding the resident to use it for assistance as needed, anticipating and meeting the resident's needs, providing routine rounding and offering assistance as needed, reviewing information on past falls and attempting to determine the cause of falls, recording possible root causes and removing any potential causes if possible. III. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 9/26/24 at 9:00 a.m. CNA #5 said if a resident was a fall risk their Kardex (a tool utilized to assist staff with providing resident care) would list what interventions were in place. CNA #5 said Resident #20 liked to get out of bed on her own and did not use her call light for assistance. CNA #5 said Resident #20 had a fall mat when she was in bed, they kept her bed in the lowest position, did frequent checks on the resident and made sure her touchpad call light was near her. She said the call light should be right next to her, hooked to her pants or her wheelchair. Registered nurse (RN) #2 was interviewed on 9/26/24 at 10:58 a.m. RN #2 said if a resident was at risk for falls they should have a fall care plan with fall interventions. RN #2 said the staff reviewed the fall interventions during the nurse report and communicated them with the CNAs. RN #2 said it was the nurses job to oversee fall interventions and make sure they were implemented. She said the CNAs were responsible for making sure interventions were in place. RN #2 said Resident #20 had a history of falls. She said the facility put a lot of interventions in place for her, but the resident still believed she could get up without help. RN #2 said staff checked on her frequently, and if she was getting restless, they offered to take her to the bathroom. She said staff made sure the call light was within reach and provided continual reminders for her to call for assistance. RN #2 said if the resident was up in her wheelchair the call light should be clipped onto her clothing where she could reach it. RN #2 said Resident #20's call light should not be left on the bed behind her where the resident could not see it or reach it. The director of nursing (DON) was interviewed on 9/26/24 at 2:40 p.m. The DON said call lights should always be within reach for the residents. He said Resident #20's call light should be close to her so she could see it and reach it easily.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to ensure that a resident who displayed or was diagnosed with a mental disorder received appropriate interventions to correct behaviors or to attain the highest practicable mental and psychosocial well-being for one (#11) of one resident out of 45 sample residents. Specifically, the facility failed to ensure person-centered individualized interventions were implemented for Resident #11's behaviors. Findings include: I. Resident #11 A. Resident status Resident #11, age 66, was admitted on [DATE]. According to the September 2024 computerized physicians orders (CPO), diagnoses included schizoaffective disorder, depressive episodes, anxiety and dementia. The 6/24/24 minimum data set (MDS) assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident had verbal behaviors directed towards others, rejected care and used a wheelchair due to impairments in her upper and lower extremities on both sides. The resident was dependent on staff for toileting and personal hygiene. B. Observations On 9/24/24 during a continuous observation, beginning at 2:51 p.m. and ending at 3:30 p.m., the following was observed: At 2:51 p.m. licensed practical nurse (LPN) #4 was sitting at the nurses station. LPN #4 yelled an expletive, made a loud sigh, pounded on the desk and yelled at Resident #11 to get out of the room on the right (this room was a living room/break room area for staff and residents). Resident #11 said she needed to blow her nose and LPN #4 told her to come to the nurses station where he was sitting and he would help her. At 2:53 p.m. Resident #11 asked LPN #4 if she could smoke. LPN #4 told Resident #11 that he already told her no and the next smoke break was at 4:00 p.m. Resident #11 aggressively turned her wheelchair around and the wheel hit the wall. -LPN #4 did not attempt to redirect Resident #11's aggressive behavior. At 2:55 p.m. Resident #11 again asked LPN #4 if she could smoke. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #4 did not respond or acknowledge the resident. At 2:58 p.m. Resident #11 asked LPN #4 if she could smoke for a third time. LPN #4 told her no. Resident #11 asked how long until she could smoke and LPN #4 did not respond to the resident. Resident #11 aggressively turned her wheelchair and went down the hallway. -LPN #4 did not attempt to redirect Resident #11's aggressive behavior. At 3:23 p.m. Resident #11, another resident and a staff member were near the nurses station where LPN #4 was sitting. LPN #4 told everyone to stop, please stop. Resident #11 told LPN #4 her eyes were bothering her. LPN #4 approached the resident and told her it was probably allergies and directed her to rinse her eyes with water. The resident requested eye drops instead and LPN #4 administered the drops then walked away in a [NAME] and said good lord. At 3:30 p.m. Resident #11 asked LPN #4 if she could smoke again. LPN #4 told Resident #11 to stop and said she had not missed a smoke break yet today. -LPN #4 did not attempt to redirect Resident #11 from her repeated requests for a smoke break. On 9/25/24 at 9:06 a.m. Resident #11 yelled that she had to pee and asked registered nurse (RN) #2 to take her to the bathroom. RN #2 told Resident #11 to take her medicine first. Resident #11 continued to yell that she had to pee and asked RN #2 again to take her to the bathroom. Resident #11 said she was not going to take her medicine and that she had to pee. RN #2 told Resident #11 to take her medicine first and Resident #11 again said no. At 9:12 a.m. Resident #11 took her medicine and asked again to go to the bathroom. At 9:13 a.m. certified nurse aide (CNA) #2 assisted Resident #11 to her room to use the restroom, seven minutes after the resident initially requested to go to the bathroom. On 9/26/24 at 2:25 p.m. Resident #11 was yelling in the main hallway that someone had hit her. -An unidentified staff member started joking with Resident #11 about donuts and did not acknowledge or question Resident #11 about the situation. C. Record review The care plan, dated 9/18/24, revealed the resident had a history of behavioral problems of verbal and physical aggression with poor safety awareness. Interventions included offering tasks that diverted the resident's attention. D. Staff interviews The director of nursing (DON) was interviewed on 9/26/24 at 12:32 p.m. The DON said when Resident #11 was having repetitive behaviors, staff should redirect her by offering activities, taking her outside or engaging in conversation with her. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical consultant (CC) and the social services consultant (SSC) were interviewed together on 9/26/24 at 2:05 p.m. The CC said Resident #11 changed her mind often and required firm boundary setting. She said staff should offer to take her outside, visit with social services and offer to spend time with her discussing life.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure one (#34) of five out of 45 sample residents were as free from unnecessary medications as possible. Specifically, the facility failed to: -Ensure the unapproved off label use of an antipsychotic medication (Seroquel) was not used for insomnia, for Resident #34; -Ensure the gradual dose reduction (GDR) recommendations were followed up on for Resident #34; and, -Ensure a consent was obtained for the use of the antipsychotic medication (Seroquel) for Resident #34. Findings include: I. Resident #34 A. Resident status Resident #34, age 65, was initially admitted on [DATE], discharged to an assisted living facility on 12/19/23 and readmitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included multiple sclerosis (an autoimmune condition that affects the brain and spinal cord central nervous system) and insomnia (difficulty sleeping). The 6/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He was dependent upon staff for assistance with oral hygiene, toileting, bathing, lower body dressing and personal hygiene. The MDS documented Resident #34 was prescribed an antipsychotic medication. B. Record review The September 2024 CPO documented Resident #34 was prescribed Quetiapine Fumarate (Seroquel) 50 milligrams (mg), give one tablet by mouth at bedtime for insomnia ordered on 8/19/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The use of antipsychotic medication care plan, initiated on 1/5/24, documented Resident #34's use of an antipsychotic medication for insomnia. The interventions included administering psychotropic medications as ordered by physician, monitoring for side effects and effectiveness, completing an abnormal involuntary movement scale (AIMS) assessment quarterly or as needed, monitoring behaviors identified for the antipsychotic medication, discussing with the medical doctor (MD), power of attorney (POA) and family regarding the ongoing need for use of the medication, reviewing behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, reviewing medications with the interdisciplinary team (IDT) quarterly and as indicated and attempting a GDR when clinically indicated. The 4/25/24 psych-pharm management progress note documented the resident was prescribed Quetiapine Fumarate 50 mg for insomnia and Trazodone HCl (anti-depressant) 50 mg for sleep as needed. The recommendations included to track the resident's hours of sleep for the use of the Trazodone and consider a GDR of Trazodone next quarter. -The psych-pharm meeting did not address Resident #34's unapproved and off label use of the Seroquel medication. The 7/25/24 psych-pharm management progress note documented Resident #34 was prescribed Quetiapine Fumarate (Seroquel) 50 mg one time per day for insomnia. The recommendations included reducing the Seroquel to 25 mg. -However, according to the September 2024 medication administration record (MAR) Resident #34 was still prescribed 50 mg of Seroquel one time per day. The facility did not follow through on the recommendations to reduce the Seroquel from 50 mg to 25 mg on 7/25/24. A review of Resident #34's medical record did not reveal documentation that the facility had obtained consent prior to the administration of the Seroquel. C. Staff interviews The social services consultant (SSC) was interviewed on 9/26/24 at 5:29 p.m. The SSC said the use of Seroquel for insomnia was an unapproved off-label use of the medication. She said there was no clinical justification for use of Seroquel for insomnia. The SSC said she did not know why Resident #34 was prescribed two medications for insomnia. She said was unable to find documentation to indicate a medical justification for the unapproved off label use of the Seroquel for insomnia. The SSC said the GDR recommendations were made during the monthly psych-pharm meetings. She said a GDR recommendation should be followed up on within seven days. She acknowledged the GDR recommendation had not been followed up on since Resident #34 was still prescribed Seroquel 50 mg one time per day instead of 25 mg on time per day. II. Facility follow-up (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the survey process (9/23/24 - 9/26/24), the facility provided documentation on 9/27/24, that the resident's primary care physician (PCP) was contacted regarding the unapproved off label use of Seroquel for Resident #34. The physician responded to discontinue the Seroquel. The facility provided a consent dated 11/10/23 for the use of Seroquel, however Resident #34 had a planned discharge from the facility to an assisted living community (December 2023). This consent was from his previous admission to the facility.

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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. 50853 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 five medication carts and one of three medication storage rooms. Specifically, the facility failed to ensure expired medications were removed from the medication carts and medication storage rooms. Findings include: I. Professional reference The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 9/30/24 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. II. Observations On 9/25/24 at 2:58 p.m. medication cart #1 on the Sunshine Peak hall was observed with certified nurse aide with medication authority (CNA-Med) #1. The following item was found: -One bottle of atropine (involuntary nervous system blocker medication)10 milligrams (mg)/milliliter (ml) oral suspension with an expiration date of 3/8/24. On 9/25/24 at 3:26 pm the medication cart on Red Cloud Peak hall was observed with registered nurse (RN) #2. The following items were found: -One bottle of calcium with vitamin D 10 micrograms (mcg) with an expiration date of August 2024. -One bottle of abacavir and lamivudine (epzicom) (human immunodeficiency virus medication) 600 mg/300 mg tabs with an expiration date of 5/31/24. On 9/26/24 at 10:16 a.m. the station three medication room was observed with the director of nursing (DON). The following items were found: -One container of daptomycin (an antibiotic) 500 mg/50 ml compounded intravenous (IV) solution with an expiration date of 9/16/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two boxes of Dermaprep liquid barrier skin preparation (forms a protective coating on the skin) with an expiration date of 5/17/24. III. Staff interviews CNA-Med #1 was interviewed on 9/25/24 at 3:00 p.m. CNA-Med#1 said the atropine medication should have been removed from the cart when it expired. RN #2 was interviewed on 9/25/24 at 3:30 p.m. RN #2 said the calcium with vitamin D that was in the Red Cloud Peak medication cart was just delivered today. She said the expiration date should have been checked prior to placing the medication in the cart. She said the night shift usually checked the expiration dates. RN #2 removed the expired medications from the cart and said she would dispose of them. The DON was interviewed on 9/26/24 at 10:20 a.m. The DON said the nurses checked the medication carts daily for expired medications. He said there should not be expired medications in the carts or storage rooms.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48114 Based on interviews, record review and observations the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value, palatable in taste, texture and temperature. Specifically the facility failed to ensure the resident food was palatable in taste, texture and temperature. Findings include: I. Facility policy and procedure The Meal Preparation for Nutritive Value and Palatability policy and procedures, revised April 2023, was received from the nursing home administrator (NHA) on 9/27/24 at 5:07 p.m. It read in pertinent part, Food is prepared by methods that conserve nutritive value, flavor, and appearance. Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Food is not prepared too far in advance of meal service. Food is prepared using acceptable standards of cooking. Hot food is not on the steam table ready to serve until 30 minutes prior to serving residents. Meal service is timed for tray/cart delivery within reasonable time limits to preserve temperature and quality of food. II. Resident interviews Resident #70 was interviewed on 9/23/24 at 1:35 p.m. She said she ate two sandwiches a day because the food was always served cold. Resident #24 was interviewed on 9/23/24 at 3:23 p.m. Resident #24 said the food served was cold all of the time. She said the food did not taste good most of the time. Resident #203 was interviewed on 9/23/24 at 4:05 p.m. She said the food served was always cold. Resident #18 was interviewed on 9/24/24 at 9:31 a.m. She said the room trays were sometimes cold. She said sometimes the certified nurse aides (CNA) were behind and were not able to get the trays out right away. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #251 was interviewed on 9/24/24 at 11:47 a.m. She said she only ate turkey and peanut butter and jelly sandwiches recently, because she did not like the food. She said the food had no flavor to it and was not prepared well. She said overall the food was not good. Resident #49 was interviewed on 9/24/24 at 12:15 p.m. He said the hot food was not served hot. He said he did not like the choices the facility had on the menu. He said most of the time he ordered take out food. III. Observations During a continuous observation on 9/26/24, beginning at 10:25 a.m. and ending 12:27 p.m., the following was observed during the lunch meal preparation and service in the main kitchen. -At 10:59 a.m. the cook (CK) #1 began preparing the resident's plates for the restorative unit. CK #1 put the food on a styrofoam plate, covered the plate in plastic wrap and placed it on the counter. An unidentified CNA then put the plate on an uninsulated rolling cart. -At 11:09 a.m. the last plate was placed on the rolling cart and the cart was taken to the restorative unit for room trays. -At 11:09 a.m. CK#1 began preparing the resident's plates for the secured unit. CK #1 placed the food on a plate, covered the plate in plastic wrap and placed it on the counter. An unidentified CNA placed the plate on a rolling cart. -At 11:22 a.m. the last plate was placed on the rolling cart and the cart was taken to the secured unit for room trays. -At 11:22 a.m. CK #1 plated the first plate for the dining room. The food was served on a styrofoam plate. -At 11:36 a.m. CK #1 began plating up the plates for the first hallway trays for the 200 hallway. CK #1 placed the food on the styrofoam plates, covered them in saran wrap and placed them on the counter. An unidentified CNA placed the plates on a tray and placed them on a multiple tier cart that was open. -At 11:58 a.m. CK #1 plated the last plate, covered it with plastic wrap and placed it on the counter. An unidentified CNA placed the plate on the tray and placed it on the uninsulated cart. The unidentified CNA delivered the room trays to the 200 hallway. -At 12:02 p.m. CK #1 began preparing the plates for the 300 hallway. CK #1 placed the food on the styrofoam plates, covered them in plastic wrap and placed them on the counter. An unidentified CNA placed the plates on an uninsulated cart. -At 12:13 p.m. CK #1 prepared the last plate, covered it in plastic wrap and placed it on the counter. An unidentified CNA placed the on the uninsulated cart and delivered the plates to the 300 hallway. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Pointe Care Center	1655 Yarrow St Lakewood, CO 80214

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:13 p.m. CK #1 began plating the first plate for the 400 hallway. CK #1 placed the food on the styrofoam plates, covered the plates in plastic wrap and placed them on the counter. An unidentified CNA placed the plates on an uninsulated cart for the 400 hallway. -At 12:25 p.m. CK #1 prepared the last plate, covered it up in plastic wrap and placed it on the counter. An unidentified CNA placed the plate on an uninsulated cart and exited the dining room at 12:27 p.m. to deliver the trays to the 400 hallway. A test tray for a regular diet was evaluated by five surveyors immediately after the last resident had been served their room tray for lunch on 9/26/24 at 12:42 p.m. The regular diet test tray consisted of lemon herb chicken, oven roasted parmesan potatoes, green beans, a dinner roll and strawberry shortcake fluff. -The lemon herb chicken was dry. -The oven roasted parmesan potatoes were 115.7 degrees F. The potatoes were bland and dry. -The green beans were 119 degrees F. The green beans were bland. -The dinner roll was soggy. IV. Record review The food committee meeting minute notes were received from the dietary manager on 9/17/24 at 1:15 p.m. The food committee minute notes from 8/14/24 documented in pertinent part, The residents said some days they were served vegetables and some days they were not served vegetables. -There was no documentation indicating a resolution to the concerns regarding vegetables brought up in the food committee. V. Staff interviews The dietary manager (DM) was interviewed on 9/26/24 at 1:34 p.m. The DM said he was aware of the concerns about the food being served cold. He said only one side of the plate warmer was working and the other side was currently broken. He said one side of the plate warmer had not been working for a while. He said he informed the NHA that he was waiting for the plate warmer to be repaired. He said the kitchen staff were trying to get the room trays out to the residents quicker. He said the facility did not have any hot boxes to transport the room trays in. The DM said maintenance had shut the water off in the morning, so he had to use styrofoam plates to serve lunch. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM said the food committee was held monthly. He said there were not a lot of residents who attended the meeting. He said the residents who attended the monthly meeting had never complained about the food. He said if more residents attended the meetings and voiced their concerns then he could address the concerns. The DM said he had never run out of food. He said the cooks had been preparing extra food because the census had been going up. He said he did not work on the weekends so he was not aware of any concerns about the food running out and alternatives being served. The DM said the alternative menu was posted outside the dining room. He said the alternative menu was always available for the residents to order off of. He said the last time it was updated was last year. He said the main menu was rotated every six months. He said the menu was in the summer/spring season and would soon be changing over to the fall/winter menu. The NHA was interviewed on 9/26/24 at 1:45 p.m. The NHA said he was aware of the concerns from the residents about the food being cold. He said the common complaint he had heard from the residents was that the vegetables were too hard or too soft. He said he had encouraged those residents to eat their meals in the dining room. He said that the facility did not have any hot boxes to transport the room trays. He said he had ordered a plate warmer and was waiting for it to arrive. He said he did not know when he ordered the plate warmer. He said once the plate warmer was repaired that it should help fix the cold plate problem. The NHA said all the meals were served on the regular plates. He said he did not know why lunch was served on the styrofoam plates. The NHA said he had encouraged all the residents to attend the food committee meeting that was held once a month. He said he had told the residents to attend so that they could voice their concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections throughout the facility. Specifically, the facility failed to: -Ensure housekeeping staff disinfected high touch surfaces (call lights, door handles and light switches) in resident rooms; -Ensure areas were cleaned from clean areas to dirty areas; -Ensure hand hygiene was performed appropriately during the cleaning of resident's rooms; -Ensure linen was transported and stored appropriately; -Ensure equipment used for multiple residents was cleaned regularly; and, -Ensure residents did not share cutlery and food items. Findings include: I. Ensure professional standards of infection control were followed when cleaning resident rooms A. Professional reference According to The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 9/30/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, 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; and, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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. According to the CDC Hand Sanitizer Guidelines and Recommendations (3/12/24), was retrieved on 9/20/24 from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html Apply the gel product to the palm of one hand (read the label to learn the correct amount), cover all surfaces of hands and rub your hands and fingers together until they are dry. This should take around 20 seconds. B. Facility policy and procedure The Hand Washing and Hand Hygiene policy, dated 2019, was provided by the NHA on 9/27/24 at 5:07p.m. It read in pertinent part; Using Alcohol-Based Hand Rubs: apply a generous amount of product to the palm of hand and rub hands together. Cover all surfaces of hands and fingers until hands are dry. C. Observations During a continuous observation on 9/25/23, beginning at 9:00 a.m. and ending at 9:26 a.m. the following was observed: Housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER], a double occupancy room. HSK #1 performed applied hand sanitizer foam, rubbed his hands together for less than 10 seconds and then applied gloves to his visibly wet hands. HSK #1 had difficulty donning (putting on) the gloves because his hands were not completely dry. HSK #1 entered room [ROOM NUMBER] and emptied all of the trash. HSK #1 removed his gloves, sanitized his hands and donned clean gloves. He sprayed Clorox urine remover on the toilet and toilet room floor, said he would leave the solution on for at least five minutes and he would clean this last (However, HSK #1 did not clean the toilet last). HSK #1 sprayed Oxivir cleaning solution on the sink, over bed tables, window sill and other furniture. HSK #1 said he would let this set for at least one minute. HSK #1 removed his gloves, performed hand hygiene and donned clean gloves. He said the bathroom chemicals had been sitting for over five minutes and he cleaned the toilet and toilet room. HSK #1 wiped the toilet tank, sharps container, windowsill, heat register, shelf and toilet. He removed his gloves and performed hand hygiene. He donned new gloves and mopped the bathroom floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSK #1 performed hand hygiene, donned gloves and obtained two clean towels. He set one clean towel on the commode lid on side one of the room and wiped furniture and the windowsill on side two (by the window). He performed hand hygiene and changed gloves, then wiped down furniture on side one using the rag that was laying on the commode. HSK #1 performed hand hygiene, donned clean gloves and mopped the floors. HSK #1 removed his gloves, used hand sanitizer and moved his cart to the next room. He donned gloves and entered room [ROOM NUMBER] and began gathering trash. -Each time HSK #1 used hand sanitizer, he rubbed it into his hands for less than 10 seconds and applied gloves to visibly wet hands. -HSK #1 did not clean the call lights, door handles or light switches. D. Staff interviews HSK #1 was interviewed on 9/26/24 at 9:26 a.m. HSK #1 said he usually cleaned the bathroom first to get it out of the way. The housekeeping/laundry supervisor (HLS) was interviewed on 9/26/24 at 3:54 p.m. The HLS said hand sanitizer should be rubbed into hands for 30 seconds or until hands were dry. The HLS said clean towels should not be set down on dirty surfaces prior to use because they could become contaminated. She said the bathroom should be cleaned last. She said if the sink was not in the same room as the toilet, it should be cleaned before the toilet. The HLS said high touch surfaces such as the bedside table, night stand, call light and door knobs should be cleaned every day. The infection preventionist (IP) was interviewed on 9/26/24 at 3:40 p.m. The IP said resident rooms should be cleaned in order of cleanest surfaces to dirtiest. She said the bathroom and toilet should be cleaned last because it is considered the dirtiest area She said a clean towel should not be put on top of a used commode and then used to clean the room. The IP said this would be a concern for infection because the commode was considered dirty. II. Ensure linen was transported and stored appropriately A. Facility policy and procedure The Linen policy, dated 2022, was provided by the NHA on 9/27/24 at 5:07p.m. It read in pertinent part, Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. B. Observations On 9/24/24 at 9:23 a.m. a linen cart containing clean linens was observed uncovered on the 200 hall. On 9/24/24 at 2:43 p.m. an unidentified certified nurse aide (CNA) pushed a linen cart down the 300 hall. There were folded gowns and bed pads on top of the cart and not covered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 10:33 a.m. an unidentified laundry aide unloaded a linen cart off of the dumbwaiter (a small elevator used to transport linen). There were clean personal linens on hangers in the cart and it was not covered. C. Staff interviews The HLS was interviewed on 9/26/24 at 3:54 p.m. The HLS said when clean linen was transported it should be covered to prevent contamination. The IP was interviewed on 9/26/24 at 3:40 p.m. The IP said clean linen should be covered when transported in the hallways. III. Ensure equipment used for multiple residents was cleaned regularly A. Professional reference According to The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24),was retrieved on 9/30/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, Best practices for selection and care of noncritical patient care equipment: Clean all equipment using the methods and products available at the facility. All equipment should include detailed written instructions for cleaning and disinfection from the manufacturer, including pictorial instructions if disassembly is required. Train the staff responsible for cleaning equipment on procedures before the equipment is placed into use. Shared equipment should be cleaned before and after each use. B. Facility policy and procedure The Cleaning and Disinfecting Environmental Surfaces policy, dated 2019, was provided by the nursing home administrator (NHA) on 9/27/24 at 5:07p.m. It read in pertinent part; Environmental surfaces will be cleaned and disinfected according to current Center for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) blood borne pathogens standard. Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily, three times per week) and when surfaces are visibly soiled. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 2:43 p.m. a sit to stand mechanical lift was taken into a resident room on the 200 hall. The platform base, where the resident's place their feet, was full of debris,crumbs, a pepper packet and dirt. On 9/25/24 at 3:55 p.m. dirty towels were laying on top of a sit to stand lift that was stored in the 200 hall. D. Staff interviews The director of nursing (DON) was interviewed on 9/26/24 at 3:46 p.m. The DON said mechanical lifts should be cleaned daily by the night shift staff. He said dirty towels should be put in the laundry bin not laid on top of equipment in the hall. 47960 IV. Failure to ensure Resident #71 and Resident #95 did not share utensils and plates of food A. Observations A continuous observation on 9/23/24, beginning at 11:15 a.m. and ending at 12:15 p.m. The following was observed: At 11:49 a.m. Resident #95 carried her lunch plate to the staff to place in the dirty dish bin. Resident #95 returned to the dining table, sat down where Resident #71 had been sitting and began using Resident #71's utensils to eat the food that remained on Resident #71 plate. -The staff in the dining room did not provide redirection to Resident #95 when she began using Resident #71's utensils. A continuous observation on 9/25/24, beginning at 9:35 a.m. and ending at 12:49 p.m. the following was observed: At 12:06 p.m. Resident #95 took a roll off of Resident #71's plate and placed it on her plate. At 12:07 p.m. Resident #95 moved her plate with her utensils to the center of the table. At 12:08 p.m. Resident #71 moved Resident #95's plate in front of him. Resident #71 began eating the food on Resident #95's plate with Resident #71's utensils. -The staff in the dining room did not provide redirection to Resident #95 when she began using Resident #71's utensils and eating off of his plate. B. Staff interviews CNA #1 was interviewed on 9/25/24 at 12:26 p.m. CNA #1 said the residents should not share plates and utensils. She said all of the staff on the unit were responsible for watching the residents during meal times. She said sharing plates and utensils could lead to the spread of viruses between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 9/26/24 at 12:32 p.m. The DON said residents should not share plates of food or utensils because it could lead to the spread of infection or viruses between residents.