STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065307	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure each resident had the right to formulate an advanced directive for one (#63) of two residents out of 46 sample residents. Specifically, the facility failed to ensure Resident #63's proxy selected or refused life-saving treatments within the power of a proxy. Findings include: I. Medical Orders for Scope of Treatment (MOST) form The MOST form documented that a Proxy-by-Statute (decision maker selected through a proxy process) may not decline artificial nutrition or hydration for an incapacitated resident without an attending physician and a second physician trained in neurology who certified that artificial nutrition or hydration would merely prolong the act of dying and was unlikely to result in the restoration of the resident to independent neurological functioning. II. Resident status Resident #63, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included vascular dementia, atrial fibrillation (irregular heart rhythm), stroke and anxiety. The [DATE] minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. III. Record review A proxy selection document, completed on [DATE], revealed that Resident #63 lacked decision-making capacity after experiencing multiple strokes and had a proxy appointed. Resident #63's MOST form, completed on [DATE], documented the resident was a do-not-resuscitate (DNR), indicating the resident did not want cardiopulmonary resuscitation (CPR). Resident #63's MOST form was completed by his proxy and the proxy declined artificial nutrition on [DATE]. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility failed to have a physician's note signed by the resident's physician and a neurologist declaring the artificial nutrition was only prolonging death, as was required and instructed on the MOST form (see above). IV. Staff interviews The social services director (SSD) was interviewed on [DATE] at 3:41 p.m. The SSD said he was not sure what the legal difference between a proxy and a power of attorney for healthcare was. The SSD reviewed the instructions printed on the back of Resident #63's MOST form. The SSD said he was not aware a proxy could not choose to decline artificial nutrition by tube without supporting documentation by a physician. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on [DATE] at 4:51 p.m. The DON said a proxy was similar to a power of attorney with less legal power. The DON said she did not know if there was any part of the MOST form a proxy could not complete. The DON reviewed Resident #63's MOST form. The DON said she was not aware a proxy could not decline artificial nutrition by tube without supporting documentation by a physician. The NHA said a proxy could not complete the section outlining artificial nutrition on a MOST form. The NHA said Resident #63's MOST form would be updated today ([DATE]) to reflect only the decisions the resident's proxy could legally make.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for five (#63, #9, #2, #57 and #23) of ten residents out of 46 sample residents. Specifically, the facility failed to: -Implement and update fall care plans in a timely manner for Resident #63; -Ensure neurological checks were completed appropriately for Resident #63 and Resident #9 following an unwitnessed fall; -Ensure Resident #2 was safely transferred using a slide board; -Ensure Resident #57 was appropriately monitored while smoking; and, -Ensure safe transfer pole use for Resident #23. Findings include: I. Failure to initiate a timely fall care plan and interventions to prevent falls for Resident #63 and complete neurological assessments after a fall for Resident #63 and Resident #9. A. Professional reference According to [NAME], P.A., [NAME], A.G., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 1780, retrieved on 12/30/24, In the event of a fall, perform a post-fall assessment to identify possible causes. Monitor residents closely for 48 hours after a fall. B. Facility policy The Assessing Falls and Their Causes policy, revised March 2018, was obtained from the corporate consultant (CC) on 12/18/24 at 13:12 p.m. It documented in pertinent part, Falls are a leading cause of morbidity and mortality among the elderly in nursing homes. After a fall, if a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine and extremities. Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and document findings in the medical record. The falls - Clinical Protocol policy, revised September 2012, was provided by the CC on 12/18/24 at 3:12 p. m. It documented in pertinent part, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Falls should be categorized as those that occur while trying to rise from a sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to a floor. Falls should also be identified as witnessed or unwitnessed events. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try and get up and walk without waiting for assistance). The nurse evaluations required after falls list, revised 2/13/2020, was provided by LPN # 2 on 12/19/24 at 8:59 a.m. It documented that after a fall, resident vital signs must be obtained on 12 occasions in the seven hours following a fall. It documented the seven hour schedule included obtaining vital signs every 15 minutes for four assessments, then vital signs were obtained every 30 minutes for four assessments, then vital signs were obtained hourly for four hours. After frequent checks were completed for seven hours, vital signs were obtained every shift until 72 hours had passed since the fall event. C. Resident #63 1. Resident status Resident #63, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included vascular dementia, atrial fibrillation (irregular heart rhythm) and anxiety. The 10/1/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. He required set-up or clean-up assistance with eating, substantial assistance with oral hygiene and dressing and was dependent on staff to complete toileting hygiene and personal hygiene care activities. The assessment documented the resident required substantial or maximum assistance to roll left and right in bed and he required moderate assistance with all other acts of mobility. 2. Record review The fall plan of care, initiated 7/7/24 and revised 11/7/24, documented Resident #63 had experienced a fall. The plan of care documented Resident #63's goal was to be free from injury through the review date. Interventions included educating staff regarding toileting the resident and to monitor Resident #63 for 72 hours for signs and symptoms of pain, bruising, change in mental status, or any new onset of confusion, sleepiness, inability to maintain posture, or agitation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The fall risk care plan, initiated 7/7/24 and revised 11/21/24, documented that Resident #63 was a fall risk. Interventions included ensuring the resident's call light was within reach, adding a fall mat, non-skid socks, and to offer the resident toileting assistance before and after meals and at bedtime. The nursing progress note dated 7/7/24 documented that Resident #63 experienced a witnessed fall. The note documented Resident #63 was observed to slip out of his wheelchair while wheeling himself down the hallway. -The facility failed to initiate a fall prevention plan of care until after Resident #63 fell on [DATE]. The nursing progress note dated 9/16/24 documented Resident #63 experienced an unwitnessed fall in his room. The note documented staff found the resident between his bed and his night stand. The note documented the resident was unable to recall how the fall occurred. The note documented the resident's bed was not in the lowest position. The note documented Resident #63 reported pain in his knee. The neurological signs flow sheet, dated 9/16/24, documented the vital signs obtained and neurological assessments performed by nursing staff after Resident #63 fell on [DATE]. The flow sheet documented eight neurological assessments that occurred between 3:00 p.m. and 5:30 p.m. on 9/16/24. One hourly neurological assessment was documented at 7:30 p.m. The flow sheet documented Resident #63 refused one hourly assessment at 9:30 p.m. -The facility failed to perform neurological assessments per the facility's protocol (see interview below). An Interdisciplinary team(IDT) post-fall assessment dated [DATE] documented Resident #63 experienced an unwitnessed fall. The assessment documented Resident #63 was found on the floor of his room at 2:50 p.m. The neurological signs flow sheet, dated 10/11/24, documented the vital signs obtained and neurological assessments performed by nursing staff after Resident #63 fell on [DATE]. The flow sheet documented Resident #63 was assessed eight times out of 12 opportunities between 3:00 p. m. and 10:00 p.m. -The facility failed to perform neurological assessments per the facility's protocol (see interview below). An IDT post-fall investigation, dated 12/9/24, documented that Resident #63 experienced a witnessed fall on 12/9/24. The investigation documented new interventions included frequent checks, and that Resident #63 required assistance at times. The investigation documented the facility reviewed and updated Resident #63's plan of care. -However, review of Resident #63's fall plan of care revealed the care plan was not updated with the new fall interventions after the resident's 12/9/24 fall (see plan of care above). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note dated 12/12/24 documented that Resident #63 experienced an unwitnessed fall. The note documented the resident was found on the floor of his bedroom between the bed and the recliner. The note documented the resident was wearing his non-skid socks. The Neurological signs flow sheet, dated 12/12/24, documented the vital signs obtained and neurological assessments performed by nursing staff after Resident #63 fell on [DATE]. The facility documented 10 assessments out of 12 opportunities between 8:30 a.m. and 3:30 p.m. on 12/12/24. The 8:30 a.m. on 12/14/24 vital sign and neurological assessment documentation was left blank and undocumented. -The facility failed to perform neurological assessments per the facility's protocol (see interview below). An IDT post-fall investigation, dated 12/14/24, documented that Resident #63 experienced an unwitnessed fall on 12/12/24. The investigation documented new interventions included assisting Resident #63 with transferring back to bed. The investigation documented the facility reviewed and updated Resident #63's plan of care. -However, review of Resident #63's fall plan of care revealed the care plan was not updated with the new fall interventions after the resident's 12/12/24 fall (see plan of care above). D. Resident #9 1. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified disorder of psychological development, cerebral palsy and cerebellar ataxia (difficulty with balance). The 11/4/24 MDS assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. He required set-up or clean-up assistance while eating and was dependent on staff for assistance with all other activities of daily living (ADL). The assessment documented the resident required substantial assistance to roll left and right in bed and was dependent on nursing staff for all transfers. 2. Record review The fall care plan, initiated 5/6/23 and revised 10/24/24, documented that Resident #9 was a fall risk. Interventions included ensuring the resident's call light was within reach, encouraging the resident to go to bed when he appeared fatigued, ensuring incontinence products were positioned correctly underneath the resident, providing the resident with rest periods, utilizing a soft-touch call light while the resident was in bed and a therapy recommendation to use a stand assist with all resident transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT post-fall investigation, dated 10/14/24, documented Resident #9 experienced an unwitnessed fall on 10/14/24. The investigation documented that Resident #9 was found on the floor of his room. A review of Resident #9's electronic medical record (EMR) revealed there was no documentation of vital signs or neurological assessments performed after Resident #9's unwitnessed fall in his room on 10/14/24. Fall documentation for Resident #9's 10/14/24 fall was provided by the CC on 12/18/24 at 2:51 p.m. The fall documentation failed to include facility documentation of neurological assessments performed for Resident #9 after his unwitnessed fall on 10/14/24. -The facility failed to perform neurological assessments per the facility's protocol (see interview below). E. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 12/18/24 at 2:41 p.m. LPN #2 said when a resident experienced an unwitnessed fall, a registered nurse (RN) would assess the resident immediately and neurological assessments were performed. LPN #2 said she could not recall exactly what the neurological assessment schedule was but would find a copy of it. LPN #2 said the schedule was hand written in as fall vital signs on the list of nurse evaluations required after falls list. LPN #2 said neurological assessments must always be performed according to the schedule to make sure there was not a delayed head injury. LPN #3 was interviewed on 12/19/24 at 8:49 a.m. LPN #3 said neurological assessments were performed after a resident had experienced an unwitnessed fall or had a suspected head injury. LPN #3 said the neurological assessments were performed according to the schedule written on the list of required nursing evaluations after falls. LPN #3 said it was important to perform neurological assessments according to the schedule to make sure a resident was not injured after the fall. The director of nursing (DON) was interviewed on 12/19/24 at 4:51 p.m. The DON said a fall was any unplanned descent to the floor. The DON said when a resident experienced a fall, the DON should be notified immediately, the resident would be assessed by a RN and a resident's care plan should be updated with interventions to reflect the reason for the fall. The DON said neurological assessments should be performed according to the fall vital sign schedule documented on the list of nursing evaluations required after falls. The DON said it was important to perform neurological assessments according to the schedule in order to ensure residents did not develop a delayed head injury or brain bleed. The DON said neurological assessments could only be missed if the resident refused the assessment. The DON said the facility did not have a policy or protocol that dictated exactly how neurological assessments were to be completed in the facility, but she said nursing staff members knew what the schedule was because it was written on the nurse evaluations required after falls list. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON reviewed Resident #63's fall documentation for the falls sustained on 9/16/24, 10/11/24, 12/9/24 and 12/12/24. The DON said nursing staff did not complete neurological checks appropriately after Resident #63's unwitnessed falls on 9/16/24 and 10/11/24. The DON said nursing staff did not document neurological assessments in accordance with the expected documentation schedule. The DON said Resident #63's plan of care was not updated after he experienced two falls on 12/9/24 and 12/12/24. The DON said Resident #63's plan of care should have been reviewed and updated after each fall. II. Failure to ensure a safe transfer using a slide board for Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included acute and chronic respiratory failure, generalized muscle weakness and lack of coordination. The 9/14/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required set-up or clean-up assistance while eating, moderate assistance with oral hygiene and was dependent on staff for assistance with all other ADLs. B. Resident interview and observations Resident #2 and the director of rehabilitation (DOR) were overheard discussing Resident #2's fall on 12/16/24 at 1:59 p.m. Resident #2 informed the DOR that she was dropped on the floor this morning (12/16/24) while being transferred by two staff members using a slide board. The DOR said she was not aware of the fall and asked Resident #2 what happened. Resident #2 said the two certified nurse aides (CNA) that assisted her this morning (12/16/24) did not know what they were doing and the slide board slipped from their hands, which caused her to fall to the floor. The DOR said she had been working on educating staff members on how to use the slide board but not all staff members had received education. The DOR said all staff members were educated on using the hoyer lift and staff members should not have been using the slide board to transfer Resident #2 unless they were comfortable with doing so. Resident #2 said she was afraid to use the slide board again because she was dropped this morning (12/16/24) and requested to use the hoyer lift going forward. The DOR agreed and said she would enter an order to use a hoyer lift for the resident's future transfers. Resident #2 was interviewed on 12/16/24 at 2:04 p.m. Resident #2 said she had experienced a recent reduction in mobility in the last few days and had difficulty moving her legs. Resident #2 said she had used the slide board in physical therapy sessions but had not used the slide board with a CNA before this morning (12/16/24) when two CNAs dropped her while using the slide board. Resident #2 said she did not want to use a slide board ever again to transfer out of bed. Resident #2 said CNA #1 was one of the CNAs assisting her when she fell , but she was unsure who the other CNA was. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 and CNA #6 were overheard discussing Resident #2's fall on 12/16/24 at 2:13 p.m. in the Bookcliff Hall. CNA #1 said she was present when Resident #2 fell this morning (12/16/24) and asked CNA #6 for advice on how to prevent the fall incident from happening again in the future. CNA #6 provided CNA #1 education, including how to hold a slide board and how to safely brace a resident's knee if it began to buckle. C. Record Review An IDT progress note, dated 12/16/24, documented Resident #2 experienced a witnessed fall on 12/16/24. The note documented Resident #2 slid off a slide board during a transfer. The note documented this was the second time Resident #2 had slid off a transfer board in the last month and Resident #2 must now use a hoyer lift for all transfers. D. Staff interviews The DOR was interviewed on 12/16/24 at 2:02 p.m. The DOR said Resident #2 had experienced a decline in mobility in the last few days and the facility was working on finding the best way to transfer Resident #2. The DOR said she had used the slide board with Resident #2 in therapy sessions, which had gone well. The DOR said using the slide board was not typical in the facility and that was why she was providing education to staff members on how to use a slide board. CNA #1 was interviewed on 12/16/24 at 2:21 p.m. CNA #1 said she was present this morning (12/16/24) when Resident #2 slipped off the slide board. CNA #1 said she thought she had received training on how to use a slide board but she said she was not sure. CNA #6 was interviewed on 12/17/24 at 1:12 p.m. CNA #6 said she had received slide board education and was comfortable transferring residents with a slide board. CNA #6 said since the slide board incident with Resident #2, the resident's transfer orders had changed and now Resident #2 was to be transferred using a hoyer lift. CNA #6 said she did not know if all CNAs received education on how to use a slide board to transfer residents safely. The DON was interviewed on 12/19/24 at 4:51 p.m. The DON said staff members were provided education on how to use transfer equipment at the facility. The DON said the facility did not have documentation that slide board transfer education had been provided to staff members in the facility prior to 12/16/24. 48412 III. Failure to provide Resident #57 with appropriate monitoring while smoking A. Facility policy The Resident Smoking policy, revised August 2022, was provided by the nursing home administrator (NHA) on 12/19/24 at 5:38 p.m. It read in pertinent: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Resident smoking status is evaluated upon admission. The evaluation includes current level of tobacco consumption, method of tobacco consumption, desire to quit smoking and ability to smoke safely with or without supervision (per a completed safe smoking evaluation). The staff consults with the attending physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges based on the safe smoking evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. Any smoking-related privileges, restrictions and concerns are noted on the care plan and all personnel caring for the resident shall be alerted to these issues. The facility may impose smoking restrictions on a resident at any time if it is determined the resident cannot smoke safely with the available levels of support and supervision. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Residents who have independent smoking privileges are permitted to keep cigarettes and other smoking items in their possession. Residents are not permitted to give smoking items to other residents. Residents without independent smoking privileges may not have or keep any smoking items except under direct supervision. B. Resident #57 1. Resident status Resident #57, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), chronic diastolic (congestive) heart failure, lack of coordination, cognitive-communication deficit, weakness and dementia. The 11/1/24 MDS assessment revealed Resident #57 had a moderate cognitive impairment with a BIMS score of nine out of 15. Resident #57 had no documented behaviors. 2. Observations During a continuous observation on 12/16/24, beginning at 11:00 a.m. and ending at 12:05 p.m., the following was observed: At 11:01 a.m. Resident #57 was sitting in his wheelchair on the smoking patio smoking without a smoking apron on or a staff member present. At 11:04 a.m. the only staff member observed to be present on the Grand Mesa Hall, where the smoking patio was located, was a housekeeper who was cleaning resident rooms. At 11:13 a.m. Resident #57 self-propelled his wheelchair from the smoking patio to the nurses' station. He asked CNA #2 for another cigarette. CNA #2 asked the resident to wait a couple of minutes. At 11:29 a.m. Resident #57 asked numerous staff members if it was time to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:48 a.m. Resident #57 self-propelled outside onto the smoking patio. An unidentified female resident was taken to the smoking patio by a family member. Resident #57 asked the female resident for a cigarette. The female resident declined to give the resident a cigarette and Resident #57 self-propelled back to the nurses' station. At 12:00 p.m. Resident #57 asked CNA #2 if she was able to provide him with a cigarette. CNA #2 told the resident to head to the smoking area and she would meet him there. During a continuous observation on 12/17/24, beginning at 1:15 p.m. and ending at 3:06 p.m., the following was observed: At 1:39 p.m. Resident #57 was on the smoking patio waiting for a cigarette. CNA #5 gathered the residents' smoking materials. At 1:41 p.m. CNA #5 gave Resident #57 a cigarette and assisted him with lighting the cigarette. Resident #57 was not wearing a smoking apron. At 1:44 p.m. CNA #5 placed a smoking apron on the supervised smokers, including Resident #57, after she lit all of the residents' cigarettes. At 2:10 p.m. CNA #5 assisted some of the residents back inside the building. At 2:16 p.m. Resident #57 returned to his bedroom which was located next to the smoking patio. At 2:28 p.m. Resident #57 self-propelled to the smoking patio. He went around the corner and had his back facing the door and was hunched over. Resident #57 was smoking a cigarette without a smoking apron on or staff supervision. At 2:34 p.m. Resident #57 disposed of his cigarette and was leaving the smoking patio when RN #1 approached the patio door and asked the resident if he was ready to come inside for his medications. 3. Resident interview Resident #57 was interviewed on 12/16/24 at 2:40 p.m. Resident #57 said the facility was a dump and he was not allowed to smoke whenever he wanted. 4. Record review Resident #57's smoking care plan, initiated 8/29/24, revealed the resident was a smoker and interventions included the resident was a supervised smoker. -However, the facility failed to document a smoking apron as an intervention and what staff needed to do when the resident smoked without supervision or inside the building. Resident #57's smoking safety evaluation, completed on 7/2/24, revealed the resident was safe to smoke independently. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #57's smoking safety evaluation, completed on 8/27/24, revealed the resident was no longer safe to smoke independently and required a smoking apron with staff supervision. -However, observations revealed the resident did not consistently wear a smoking apron while smoking and was not always supervised by staff when he was smoking. The 8/27/24 progress note revealed a CNA completed rounds and smelled smoke coming from Resident #57's room. The resident was found sitting on the side of his bed smoking. Resident #57 handed the CNA his cigarettes and lighter and apologized. Resident #57 said he had a nightmare and smoked a cigarette to ensure he was in reality. The 8/30/24 progress note revealed Resident #57 had a smoking safety assessment completed. The resident was able to smoke unsupervised but needed to keep his cigarettes and lighter at the nurses' station. Resident #57's smoking safety evaluation, completed on 10/29/24, revealed the resident was safe to smoke independently. -However, the resident's 8/27/24 smoking safety evaluation documented the resident was no longer safe to smoke independently and required a smoking apron with staff supervision (see above). Resident #57's smoking safety evaluation, completed on 12/5/24, revealed the resident was no longer safe to smoke independently and required a smoking apron with staff supervision. The 12/5/24 progress note revealed Resident #57 had been downgraded to a supervised smoker after a smoking safety evaluation was completed. The 12/8/24 progress note revealed Resident #57 was found outside of his room smoking a cigarette at 8:00 p.m. The smoking material was taken to the nurses' station and the nurse informed the resident he was able to ask for his materials when he wanted to smoke outside. The 12/9/24 social services note revealed Resident #57 was upset that his smoking materials were removed. The staff reminded the resident he had accidentally smoked in the building numerous times and that he needed to be a supervised smoker to ensure the resident did not smoke inside the facility anymore. The staff told the resident there were safety concerns and the resident needed to be supervised while smoking and pointed out the burn holes the resident had on his wheelchair. The 12/11/24 social services note revealed Resident #57 met with the NHA and the social services director (SSD) to discuss the resident wanting to be an unsupervised smoker. The staff reminded the resident he smoked inside the facility and that his hospice team found numerous cigarette butts disposed of improperly in his bedroom. The resident understood. The 12/12/24 progress note revealed Resident #57 was seen smoking numerous times without a smoking apron or staff supervision. The 12/14/24 progress note revealed Resident #57 was non-compliant with smoking restrictions even though the staff provided the resident with education. The resident was borrowing smoking materials from other residents and smoked without an apron or staff supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Staff interviews CNA #2 was interviewed on 12/16/24 at 12:05 p.m. CNA #2 said Resident #57 was a supervised smoker and wanted to smoke at all hours of the day instead of at the set smoking times. She said Resident #57 received cigarettes and lighters from other residents and often snuck outside to smoke without supervision. CNA #4 was interviewed on 12/19/24 at 2:10 p.m. CNA #4 said supervised smokers were able to smoke at 9:00 a.m., 1:00 p.m., 4:00 p.m. and 8:00 p.m. She said supervised smokers wore smoking aprons and smoked two cigarettes at each smoking time. She said the residents were not allowed to hold the smoking materials which were held at the nurses' station. CNA #4 said Resident #57 got smoking materials from other residents and often smoked unsupervised. CNA #4 said the resident was a supervised smoker due to staff finding the resident smoking in his bedroom during the night. CNA #4 said it was important for the supervised smokers to be supervised to ensure the residents' safety. RN #2 was interviewed on 12/19/24 at 2:20 p.m. RN #2 said supervised smokers were able to smoke at 9:00 a.m., 1:00 p.m., 4:00 p.m. and 8:00 p.m. She said supervised smokers wore smoking aprons and smoked two cigarettes at each smoking time. She said the residents were not allowed to hold the smoking materials which were held at the nurses' station. RN #2 said Resident #57 was not on her assigned hall but that she was informed the resident was caught smoking in his bedroom, which showed he was unsafe to smoke without supervision. RN #2 said the residents were not allowed to share smoking materials but the residents did anyway. The NHA and the DON were interviewed together on 12/19/24 at 6:34 p.m. The DON said if a resident failed the safe smoking evaluation, then the resident was unable to hold their smoking materials or smoke without supervision. The DON said Resident #57 was a supervised smoker due to the resident smoking inside the facility. The NHA said the facility's leadership team talked about Resident #57's noncompliance with the supervised smoking and discussed putting the resident on a behavioral contract. The NHA said one of the residents that was suspected of giving Resident #57 smoking materials was discharging on 12/20/24 and the IDT was hopeful Resident #57 would not be able to obtain further smoking materials from other residents. The NHA said there were a lot of safety concerns around Resident #57 smoking. 41032 IV. Failure to ensure safe transfer pole use for Resident #23 A. Facility policy and procedure The Assistive Devices and Equipment policy, revised February 2021, was provided by the NHA on 12/19/24 at 1:30 p.m. It read in pertinent part, Our facility maintains and supervises the use of assistive devices and equipment for residents. Recommendations for the use of the device and equipment are based on the comprehensive assessment and documented in the resident care plan. The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with the devices and equipment. Staff and volunteers are trained to demonstrate competency on the use of devices and equipment prior to assisting or supervising residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Manufacturer's recommendations The manufacturer's recommendations for the Stander Wonder Pole Slim transfer pole were provided by the NHA on 12/19/24 at 3:30 p.m. The recommendations read in pertinent part, This product is only intended to assist users to provide balance and support during the process of sitting and standing. This product should not be used by anyone who suffers from any paralysis, symptoms of dementia, sleeping disorders, incontinence, severe pain, uncontrolled body movement, or who are unable to walk safely without assistance. It should not be used by individuals who suffer from confusion, restlessness, terminal restlessness, or who are under the influence of any medications, drugs or any substance that could impair their balance or judgment or any other condition that could affect the user's physical and mental ability to safely use this product. Serious injury or harm can result if the product is not properly installed. This product may present entrapment and or fall hazards. In order to mitigate the hazards of entrapment or falls, this product must be installed in strict accordance with the instructions set forth herein. This product must not be used by anyone who has any condition that may cause confusion, who cannot walk without assistance or is otherwise at increased risk of injury because of the propensity to fall or lose their balance including individuals who are taking medication that makes them tired or dizzy. The user must have sufficient hand strength to grasp the product while standing up without slipping. Do not install product if the ceiling is angled or if there is a suspended ceiling or if the distance between the floor and the ceiling is more than 10 feet. If the product moves when used, the product is not safe to use and must be removed immediately. Pol[TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observation, record review and interviews, the facility failed to ensure two (#9 and #65) of four residents reviewed for nutrition out of 46 sample residents received the care and services necessary to meet their nutritional needs and maintain their highest level practicable physical well-being. Resident #9 was admitted to the facility for long-term care on 11/6/15 with diagnoses of unspecified disorder of psychological development, cerebral palsy, and cerebellar ataxia (difficulty with balance). On 8/20/24, Resident #9 weighed 167.2 pounds (lbs). On 9/24/24, Resident #9 weighed 160 lbs., a weight loss of 7.2 lbs (4.3%) in one month, which was not significant. However, the facility failed to implement nutritional interventions or closer monitoring of the resident's weight to prevent further weight loss for the resident. The resident's care plan documented that the facility implemented a nutritional intervention on 11/5/24 which included providing the resident with nutritional supplements two times per day, however, the intervention did not assist the resident to gain weight and the resident's weight continued to decline. On 12/11/24, Resident #9 weighed 144.8 pounds. Resident #9 lost 15.2 lbs (9.5%) from 9/24/24 to 12/11/24, in less than three months, which was considered severe weight loss. The resident lost 22.4 lbs (13.4%) from 8/20/24 to 12/11/24, in less than six months, which was considered severe weight loss. -Despite the resident's severe weight loss, the facility failed to implement additional nutritional interventions. Due to the facility's failure to effectively implement nutrition interventions to prevent weight loss timely, Resident #9's weight sustained a severe weight loss of 9.5% in less than three months and 13.4% in less than six months. Additionally, Resident #65 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, asthma and adult failure to thrive. Upon admission, the resident weighed 268.4 pounds (lbs). On 12/3/24, Resident #65 weighed 248.8 lbs. Resident #65 sustained a 19.6 lbs (7.3%) weight change from 8/23/24 to 12/3/24, in less than six months, which was not considered significant weight loss. However, an interview with the registered dietician (RD) revealed that she was unaware Resident #65 was experiencing weight loss because the nursing staff cleaned the trigger alerting that the resident was losing weight. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutritional assessment performed by the RD on 12/2/24 documented Resident #65 was malnourished, however, the facility failed to implement nutritional interventions to address the resident's malnourishment. Findings include: I. Facility policy and procedure The Food and Nutrition policy, revised October 2017, was provided by the nursing home administrator (NHA) on 12/19/24 at 5:38 p.m. It documented in pertinent part, The multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. A resident-centered diet and nutritional plan will be based on this assessment. Meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time, and in accordance with the resident's medication requirements. Reasonable efforts will be made to accommodate resident choices and preferences. The food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new tray can be issued. Nourishing snacks are available to the residents 24 hours a day. The resident may request a snack as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns. The Nutritional Assessment policy, revised October 2017, was provided by the NHA on 12/19/24 at 5:38 p.m. It documented in pertinent part, As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preference. II. Resident #9 A. Resident status (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #9, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included unspecified disorder of psychological development, cerebral palsy and cerebellar ataxia (difficulty with balance). The 11/4/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. He required set-up or clean-up assistance while eating and was dependent on staff for assistance with all other activities of daily living (ADL). The assessment documented the resident was 66 inches (5 foot, 6 inches) tall. The assessment documented the resident weighed 161 lbs. The assessment documented the resident had not experienced any weight loss or weight gain. The assessment documented the resident did not require a specialty or therapeutic diet. B. Observations and resident interviews During a continuous observation in the main dining hall on 12/16/24, beginning at 11:18 a.m. and ending at 12:40 p.m., the following was observed: At 11:18 a.m. 13 residents were in the dining room. Resident #9 was sitting at a table by himself. At 12:14 p.m. Resident #9 was served his lunch tray. Resident #9 was provided with thick-handled silverware and a tall divided plate. At 12:26 p.m. Resident #9 finished eating his meal and self-propelled himself in his wheelchair out of the dining room. -Resident #9 was not offered additional food after consuming 100% of his lunch meal. Resident #9 was interviewed on 12/17/24 at 10:21 a.m. Resident #9 said he knew he had lost weight but did not know how much. Resident #9 said he felt weaker now than he did before. Resident #9 said the food in the dining hall did not taste good, but he would eat it anyway. Resident #9 said he sometimes felt hungry after eating a meal. Resident #9 said facility staff did not offer him extra food when he finished eating all of his food. During a continuous observation on 12/18/24, beginning at 4:26 p.m. and ending at 6:02 p.m. the following was observed: At 4:44 p.m. Resident #9 self-propelled himself into the dining room in his wheelchair. Resident #9 sat at a table by himself. At 5:35 p.m. Resident #9 received his dinner tray which included one scoop of plain mashed potatoes, a small plastic cup half full of ice cream and one small glass of chocolate milk. At 5:36 p.m. Resident #9 slammed his cup down on the table and said This meal is stupid! At 5:48 p.m. Resident #9 received an additional plate containing two sunny-side up eggs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 5:56 p.m. Resident #9 finished eating 100% of his meal and drank all of his chocolate milk. Resident #9 then self-propelled himself in his wheelchair out of the dining hall. Resident #9 was interviewed again on 12/18/24 at 6:01 p.m. Resident #9 said he ate all of his dinner and still felt hungry. Resident #9 said he would eat more food if they had something he liked to eat in the kitchen. Resident #9 said he was not offered additional food after eating his entire dinner meal today. -Resident #9 was not offered additional food after consuming 100% of his dinner meal. C. Record review The nutrition care plan, initiated 5/30/17 and revised 11/5/24, revealed a goal of maintaining Resident #9's weight through the review period and ensuring Resident #9 did not have signs or symptoms of malnutrition. Interventions included that the resident often skipped lunch, the resident was not allowed to drink coffee, obtaining and recording weights per the facility protocol, the RD to evaluate and make diet change recommendations as needed, occupational therapy to screen and provide adaptive equipment as needed, providing and serving diet as ordered, providing oral nutritional supplements and recording intakes every meal. -A review of the comprehensive care plan revealed there were no new or revised interventions implemented after the resident sustained severe weight loss on 12/11/24. Resident #9's weights were documented in the EMR as follows: -On 8/20/24, the resident weighed 167.2 lbs; -On 9/3/24, the resident weighed 162.2 lbs; -On 9/17/24, the resident weighed 160.8 lbs; -On 9/24/24, the resident weighed 160 lbs; -On 10/1/24, the resident weighed 160.8 lbs; -On 11/1/24, the resident weighed 161 lbs; -On 12/4/24, the resident weighed 142.2 lbs; -On 12/5/24, the resident weighed 145.6 lbs; and, -On 12/11/24, the resident weighed 144.8 lbs. -The resident lost 15.2 lbs (9.5%) from 9/24/24 to 12/11/24, in less than three months, which was considered severe weight loss. -The resident lost 22.4 lbs (13.4%), from 8/20/24 to 12/11/24, in less than six months, which was considered severe weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #9's December 2024 CPO revealed the following physician's orders related to nutrition: Regular diet, regular texture, thin liquid consistency, ordered 8/1/23. Offer snacks three times a day, ordered 4/26/24. Nutritional supplement, two times per day, ordered 11/5/24. Mini-nutritional assessment documentation, dated 8/6/24, documented that Resident #9 was at risk of malnutrition because he had lost between 2.2 and 6.6 lbs in the last three months and had a moderate decrease in food intake. -Despite the resident's documented risk for malnutrition, the facility failed to implement additional nutritional supplements. Dietary profile documentation, dated 11/4/24, documented that Resident #9 required partial assistance with eating. The assessment documented that Resident #9 required special utensils and/or assistive devices to eat. The profile documented that Resident #9 received regular-sized portions, had a good appetite and his favorite meal was dinner. The profile documented Resident #9 enjoyed eating grains and fruits. The profile documented Resident #9 did not like vegetables. The profile documented Resident #9 enjoyed chocolate, peanut butter and bananas. The profile documented that Resident #9 was eating snacks in between meals. Mini-nutritional assessment documentation, dated 11/5/24, documented that Resident #9 had not lost any weight, and had no decrease in food intake. The assessment documented that Resident #9 had a normal nutritional status and was not at risk of malnutrition. -However, the resident had lost 6.2 lbs between 8/20/24 and 11/1/24. The interdisciplinary team (IDT) weight variance note, dated 12/6/24, documented that Resident #9's most recent weight was 145.6 lbs and the resident had experienced a weight loss of 9.3% since he weighed 161 lbs on 11/1/24. The note documented that Resident #9's average intake was 25% to 75% of his meals. The note documented the resident had recently tested positive for COVID-19, but his intakes were improving. -However, despite the identified severe weight loss, the facility failed to implement additional nutritional interventions. Resident #9's meal intake documentation was reviewed between 11/19/24 and 12/18/24. Out of 83 meal opportunities, Resident #9 ate more than 75% of 32 meals, 51% to 75% of five meal opportunities, 26% to 50% of 13 meal opportunities and less than 25% of three meal opportunities. The facility documented Resident #9 refused his meal on 22 occasions. -However, there was no documentation in the resident's EMR of the facility re-offering meals or other meal alternatives to the resident after he refused the offered meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Additionally, the resident's nutritional plan of care did not include interventions to address Resident #9's meal refusals (see plan of care above). Resident #9's snack intake documentation was reviewed between 11/19/24 and 12/18/24. In the 30-day review period, snacks were offered three times per day on five days. The facility documented snacks were offered to Resident #9 one time per day on 21 of those days. The facility documented no snacks were offered to Resident #9 on two of those days. -The facility failed to offer snacks three times per day as ordered by the physician (see physician's orders above). III. Resident #65 A. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included chronic kidney disease, asthma and adult failure to thrive. The 11/30/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required moderate assistance with bathing and was independent of all other ADLs. The assessment documented the resident was 64 inches (5 foot, 4 inches) tall. The assessment documented the resident weighed 267 lbs. The assessment documented the resident had not experienced any weight loss or weight gain. The assessment documented the resident did not require a specialty or therapeutic diet. The assessment documented the resident did not have any rejections of care. B. Observations and resident interview Resident #65 was interviewed on 12/17/24 at 10:32 a.m. Resident #65 said she was new to the facility and did not like the food that was served. Resident #65 said when she was first admitted to the facility she would often eat breakfast in her room, however, she said the food that was delivered to her room was always cold. Resident #65 said she began going to the dining room in the last few weeks so she could eat her food when it was still warm. Resident #65 said sometimes she could not eat the food because it was room temperature. Resident #65 said she had lost weight because of the food at the facility. Cross-reference F804 for food palatability. During a continuous observation on 12/18/24, beginning at 4:26 p.m. and ending at 6:02 p.m., the following was observed: At 4:56 p.m. Resident #65 entered the dining room and sat at a table with Resident #9. At 5:36 p.m. Resident #65 received her meal tray. She received mashed potatoes with gravy, carrots, a small cup half full of ice cream and a breaded chicken breast. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 5:37 p.m. Resident #65 requested her meal be reheated because it was served cold. An unidentified staff member took Resident #65's tray to the kitchen to reheat it. At 5:39 p.m. an unidentified staff member brought Resident #65's plate of food back to her. Resident #65 began to eat her meal. At 5:59 p.m. Resident #65 left the dining room. Resident #65 had eaten only the gravy off the top of the mashed potatoes and a few carrots, but ate all of her breaded chicken and ice cream. Resident #65 was interviewed again on 12/18/24 at 6:02 p.m. Resident #65 said her food was delivered to her cold at dinner. Resident #65 said the dining staff reheated her food in the kitchen but the food was still cold. Resident #65 said she could not eat the mashed potatoes because they were cold but the gravy on top was warm enough to eat. Resident #65 said she felt very frustrated that the kitchen struggled to bring her food that was warm enough to eat. Resident #65 said she felt it was not important to the facility to serve decent food to residents. C. Record review The nutrition care plan, initiated 9/12/24 and revised 12/2/24, revealed a goal of maintaining Resident #65's weight through the review period, ensuring Resident #65 consumed more than 50% of two meals per day and ensuring Resident #65 did not have signs or symptoms of malnutrition. Interventions included providing and serving supplements as ordered, providing and serving diet as ordered and for the RD to evaluate and make change recommendations as needed. -However, the resident did not have a physician's order for nutritional supplements and there was no documentation in the resident's EMR to indicate she was receiving a nutritional supplement (see physician's orders below). Resident #65's weights were documented in the electronic medical record (EMR) as follows: -On 8/23/24, the resident weighed 268.4 lbs; -On 8/25/24, the resident weighed 266.8 lbs; -On 8/26/24, the resident weighed 267 lbs; -On 9/2/24, the resident weighed 258 lbs; -On 10/1/24, the resident weighed 254 lbs; -On 11/1/24, the resident weighed 251 lbs; and -On 12/3/24, the resident weighed 248.8 lbs. -The resident lost 19.6 lbs (7.3%), from 8/26/24 to 12/3/24, in less than six months, which was not considered significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-A review of Resident #65's December 2024 CPO failed to reveal any physician's orders for nutritional supplements. The Mini-nutritional assessment, dated 9/1/24, documented that Resident #65 was of normal nutritional status and was not at risk for malnutrition. The assessment documented Resident #65 had experienced no weight loss and had no decrease in her food intake. The Mini-nutritional assessment, dated 12/2/24, documented that Resident #65 was malnourished. The assessment documented the resident had experienced a weight loss greater than 6.6 lbs and had a moderate decrease in food intake. The assessment documented that nutritional supplements would be provided and served as ordered. -However, a review of Resident #65's December 2024 CPO revealed there were no physician's orders for nutritional supplements (see physician's orders above). Resident #65's meal intake documentation was reviewed between 11/20/24 and 12/19/24. Out of 86 meal opportunities, Resident #65 ate more than 75% on 50 meal opportunities, 51% to -75% on 16 meal opportunities, 26% to -50% on 13 opportunities and less than 25% of her meal on five opportunities. Resident #65's snack intake documentation was reviewed between 11/20/24 and 12/19/24. In 30 days of opportunities, snacks were offered to Resident #65 on nine of those days. The documentation included 11 days that Resident #65 refused snacks. IV. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 12/18/24 at 8:57 a.m. LPN #2 said she did not know if Resident #9 or Resident #65 were losing weight. LPN #2 reviewed the EMRs for Resident #9 and Resident #65. LPN #2 said Resident #9 was losing weight according to what was documented in the EMR, but she said she did not know why the resident was losing weight. LPN #2 said that offering snacks, supplements and extra food at meal times could all help Resident #9 gain weight. LPN #2 said Resident #65 had lost weight as well but she did not know why. Certified nurse aide (CNA) #7 was interviewed on 12/18/24 at 6:04 p.m. CNA #7 said Resident #9 and Resident #65 were both good at eating at dinner and sometimes enjoyed sitting together. CNA #7 said she did not know if Resident #9 or Resident #65 were experiencing weight loss. CNA #7 said she thought Resident #65 did not enjoy her meal this evening (12/18/24) because she asked it to be heated up but then did not eat it all. CNA #7 said she did not offer Resident #65 additional food because she did not seem to like what she was given the first time. LPN #3 was interviewed on 12/19/24 at 8:49 a.m. LPN #3 said when a resident experienced weight loss, the care plan would be updated and nursing staff and the RD worked together to find a way to stop the weight loss. LPN #3 said what was offered to decrease weight loss was different for every resident. LPN #3 said she did not know if Resident #9 or Resident #65 had experienced weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD was interviewed on 12/19/24 at 11:17 a.m. The RD said she had worked at the facility for two years. The RD said she came to the building once a week in the middle of the week. The RD said her nutritional assessment process included reviewing information documented in the EMR, speaking to the residents about their preferences and observing the residents in the dining room, if possible. The RD said when a resident experienced weight loss, she would perform an assessment of the resident, place a progress note in the EMR, discuss the situation weekly in the risk meeting and the resident's care plan was updated with new interventions. The RD said she input the interventions into care plans at the facility. The RD said if a resident continued to lose weight despite new interventions, the resident's care plan should be reviewed and nutritional interventions should be changed or modified. The RD said residents who experienced weight loss should have additional or alternative food offered if they ate their entire plate of food during a meal. The RD said if a resident enjoyed a dessert for example, she would see if the facility could provide a double dessert or a second serving of a food item the resident liked. The RD said it was always better for residents to get their nutrition from food rather than supplements, if possible. The RD said if a resident received a cold meal or a meal that was not palatable to them, she would want the resident to let staff know so they could fix the meal to be more palatable for the resident. The RD said she would discuss food preferences with the resident and update that information in the resident's EMR. The RD reviewed Resident #9's EMR. The RD said Resident #9 was on her radar for weight loss before she took a medical leave in September 2024, but she did not know exactly how much weight he had lost. The RD said a weight loss trigger was inaccurately cleared on 9/3/24 by registered nurse (RN) #3, during the time of her medical leave before she returned to work on 9/12/24. The RD said the clearing of the weight loss trigger caused a delay for the facility to implement interventions for Resident #9. -However, Resident #9's documented weights identified the resident sustained a 15.2 lb (9.5%) from 9/24/24 to 12/11/24, in less than three months, which was considered severe, and the facility failed to implement additional nutritional interventions for the resident (see record review above). The RD said she was not aware that Resident #65 was losing weight. The RD said that RN #3 had also cleared the weight loss trigger notification warning in the resident's EMR. The RD said without that notification, she would have to manually calculate weight loss in all residents which was not feasible. The RD said Resident #65's weight loss caught her by surprise. The RD said she had not performed further evaluation or assessment of Resident #65's weight loss. The RD said Resident #65 did not have physician's orders to obtain weights weekly and the facility should begin watching her weight more closely. The director of nursing (DON) was interviewed on 12/19/24 at 4:51 p.m. The DON said she expected the RD to identify residents who experienced weight loss. The DON said she discussed residents who experienced weight loss on a weekly basis and the IDT then determined if there were additional contributing factors to the weight loss. The DON said the IDT would find the cause for the weight loss and could recommend interventions, such as double portions or food alternatives. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The DON reviewed Resident #9's EMR. The DON said Resident #9 was not offered enough snacks. The DON said residents who experienced weight loss and consistently ate their entire meal should have additional food offered to them. The DON said Resident #65 should have palatable food offered to her. The DON said Resident #65 was not being monitored for weight loss but would be monitored more closely going forward.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review, and interviews, the facility failed to provide necessary respiratory care consistent with professional standards of practice, the resident's care plan, goals and preferences for two (#32 and #70) of two residents reviewed for respiratory care out of 46 sample residents. Specifically, the facility failed to: -Implement a care plan focus with purpose, goals and interventions to document Resident #32 and Resident #70's goals for using a Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure (CPAP/BiPAP) machine; -Develop and implement effective interventions to maintain and clean Resident #32 and Resident #70's CPAP/BiPAP machines to ensure the non-invasive mechanical ventilators were maintained in a hygienic manner; and, -Develop and implement effective interventions for oxygen therapy for Resident #32 and Resident #70. Findings include: I. Manufacturer's recommendations The ResMed AirSense10 manufactures User Guide, dated 2021, was provided by the nursing home administrator (NHA) on 12/18/24 at 1:30 p.m. It read in pertinent part, It is important that you regularly clean your AirSense 10 device to make sure you receive optimal therapy. Regular cleaning of the tubing assembly, water tub, and mask prevents the growth of germs that can adversely affect health. Wash the water tube and air tube with warm water and mild detergent, rinse thoroughly and allow to dry thoroughly. Wipe the outer machine with a dry clean cloth. Clean the water tub and remove any white powder using a solution of one part household vinegar to 10 parts water. Replace any damaged parts. Check the air filter and replace it every six months or earlier if heavily soiled with dirt or dust. The filters are not washable or reusable. The device records your therapy data, so your care provider can view the data and make changes to your therapy if required. The VOCSN (ventilator, oxygen concentrator, cough assist, suction, and nebulizer) Clinical and Technical Manual, dated 2024, was provided by the NHA on 12/18/24 at 1:30 p.m. It read in pertinent part, Clean the outside of the machine between each use with a CaviWipe, Super Sani Cloth, Oxivir or Safetec SaniZide Plus cloth. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inspect the machine: Clean the air filters and fan filters every two weeks with warm water and mild detergent; rinse and allow to air dry. Do this to ensure the internal components are protected from dirt and dust. Replace the filters every six months. Replace the external bacterial and nebulizer filters every 30 days or when compromised, and the internal bacterial filter when it becomes contaminated. II. Facility policy and procedure The CPAP/BiPAP Support policy, revised March 2015, was provided by the NHA on 12/19/24 at 3:43 p.m. It read in pertinent part, Specific cleaning instructions are obtained from the manufacturers/suppliers of the PAP device. Machine cleaning: Wipe the machine with warm soapy water and rinse at least once a week and as needed. Humidifier is used: Fill with distilled water only in the humidifier chamber. Clean the humidifier weekly and air dry. To disinfect, place the vinegar water solution in the cleaned humidifier, soak for 30 minutes and rinse thoroughly. Filter cleaning: Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. Replace disposable filters once a month. Mask, nasal pillows and tubing: Clean daily by placing in warm soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. Headgear/strap: Wash with warm water and mild detergent as needed and allow to air dry. III. Resident #32 A. Resident status Resident #32, age 74, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea and respiratory failure with hypoxia (low levels of oxygen in the body's tissues). The 12/6/24 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment indicated the resident used a non-invasive mechanical ventilator. B. Resident interview and observation Resident #32 was interviewed on 12/16/24 at 3:30 p.m. Resident #32 said her CPAP machine was very important to her health and she needed to use the machine to get a good night's sleep. Resident #32 said the nursing staff did not take measures to clean her CPAP machine, so she did it herself. She said it was too hard to clean her CPAP equipment in the sink in her room and there was no good place to dry the tubing. She said when she was home, her husband cleaned her machine for her. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #32's CPAP machine, a ResMed AirSensor 10 model, and room revealed the resident had no vinegar or detergent to be able to effectively clean her CPAP per the manufacturer's recommendations (see above). The larger hose looked dusty and had some whitish sediment inside. The CPAP nasal mask foam and straps were soiled with black marks and a pinkish-orange stain. The mask was stained with a whitish cloudy substance and was hooked to the nightstand, exposed to air and was not protected from airborne debris and bacteria. Resident #32 said she was not sure when the CPAP mask had last been replaced, but she said it had been a while. She said she had used the CPAP machine for [AGE] years. C. Record review Review of Resident #32's December 2024 CPO revealed the following physician's order: Resident to use CPAP when napping/sleeping at the setting of 15, every shift, ordered 10/23/24. -A review of Resident #32's comprehensive care plan revealed the care plan failed to document the resident's use of a CPAP machine and oxygen therapy. IV. Resident #70 A. Resident status Resident #70, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included COPD, respiratory failure with hypoxia and heart failure. The 12/8/24 MDS assessment revealed the resident had intact cognition, however, the BIMS assessment was not completed. The assessment indicated the resident was receiving oxygen therapy and was using a non-invasive mechanical ventilator. B. Resident interview and observation Resident #70 was interviewed on 12/16/24 at 3:30 p.m. Resident #70 said he rented his BiPAP machine from a respiratory provider and the provider checked on the machine once in a while. Resident #70 said he was responsible for cleaning the machine, but he said he was unable to take the tubing and water reservoir apart to clean it due to his limited finger dexterity. Observation of the resident's BiPAP machine, a VOCSN model, revealed the resident had no supplies to clean the machine. The BiPAP mask was placed in the machine stand basket with miscellaneous items exposed to air and was not protected from airborne debris and bacteria. C. Record review Review of Resident #70's December 2024 CPO revealed the following physician's orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respiratory Orders: BIPAP with 6 LPM (liters per minute) of oxygen bled in at night to maintain O2 (oxygen) saturation between 87 to 94 percent (%) one time a day for COPD, ordered 8/27/24. Continuous oxygen at 6 LPM by nasal cannula. Titrate O2 to keep O2 saturation between 87% to 94%, every shift for COPD, ordered 8/27/24. -A review of Resident #70's comprehensive care plan revealed the care plan failed to document the resident's use of a BiPAP machine and oxygen therapy. V. Staff interviews Registered nurse (RN) #4 was interviewed on 12/18/24 at 11:25 a.m. RN #4 said the daytime nurses were not responsible for maintaining the residents' CPCP/BiPAP machines. She said the night shift nurses changed the oxygen in each of the residents' oxygen devices once a week. RN #4 said she thought the night nurses also cleaned the residents' oxygen machines at night but was not sure what they did to clean the machines. Licensed practical nurse (LPN) #3 was interviewed on 12/19/24 at 1:30 p.m. LPN #3 said the night nurses were responsible for maintaining and cleaning Resident #32 and #70's CPAP/BiPAP machines. The director of nursing (DON) and the NHA were interviewed on 12/19/24 at 4:00 p.m. The DON said the residents' CPAP and BiPAP machines were managed by the respiratory provider who supplied them to the resident. The DON said the company would come to the facility weekly to change tubing and maintain the equipment. The DON said the CPAP/BiPAP mask and tubing should be washed daily and believed the resident or their family were performing those tasks.

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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. 48412 Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures. Specifically, the facility failed to ensure food was palatable and served at the appropriate temperature. Findings include: I. Facility policy and procedure The Food and Nutrition Services policy, revised October 2017, was provided by the nursing home administrator (NHA) on 12/19/24 at 5:38 p.m. It read in pertinent part, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive and it is served at a safe and appetizing temperature. If an incorrect meal is provided to a resident, or a meal does not appear palatable, the nursing staff will report it to the food service manager so that a new food tray can be issued. II. Resident interviews Resident #11 was interviewed on 12/15/24 at 1:59 p.m. Resident #11 said the food was always served cold. Resident #11 said the food was bland and did not taste good. Resident #51 was interviewed on 12/16/24 at 9:02 a.m. Resident #51 said the food was served cold. Resident #10 was interviewed on 12/19/24 at 8:51 a.m. Resident #10 said the food was served cold. Resident #65 was interviewed on 12/18/24 at 6:02 p.m. Resident #65 said she received a chicken cordon bleu with hollandaise sauce, carrots, mashed potatoes with gravy and a dinner roll. Resident #65 said her meal was not good and the food was served cold. She said the staff offered to reheat the plate for the resident. She said after her plate was reheated her food was still cold. Resident #65 said her mashed potatoes were extremely cold. Resident #65 said each time she received cold food she did not want to eat it and felt it was not important to the facility to serve decent food to the residents. III. Resident group interview (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A group interview consisting of five residents (#229, #35, #8, #36 and #20) who were assessed by the facility to be interviewable was conducted on 12/19/24 at 5:58 p.m. The residents said meals were served cold and it did not matter if the residents ate in their rooms or the dining room. Resident #20 said the food was bland and most of the time cheese was not served melted. IV. Observations Dinner observations were completed on 12/18/24 and revealed the following: The cook (CK) prepared chicken cordon bleu with a hollandaise sauce, mashed potatoes with gravy, cooked carrots, dinner roll and ice cream. The alternative meal was served as Italian wedding soup with the residents choice of sides. A test tray for a regular diet was evaluated by three surveyors immediately after the last resident had been served their room tray for dinner on 12/18/24 at 6:16 p.m. The test tray consisted of chicken cordon bleu without the hollandaise sauce, mashed potatoes with gravy, a dinner roll and Italian wedding soup. The Italian wedding soup was 115.5 degrees Fahrenheit (F). The soup was salty and the vegetables were undercooked. The mashed potatoes were gummy and gritty. The chicken cordon bleu felt lukewarm and had a temperature of 121 degrees F V. Resident council notes Resident council notes from 12/6/24 revealed the residents were concerned they were still not receiving food that was hot, especially in the dining room. The residents said when they requested their food to be warmed up it was still served cold. VI. Staff interviews The dietary manager (DM), the NHA and the director of nursing (DON) were interviewed together on 12/19/24 at 6:11 p.m. The DM said he had to leave during the meal service and was confident in his team's ability to serve dinner. The DM said he failed to try the CK's food before he had to leave. The DM said the soup had been cooking for hours and the vegetables should have been softened by the time it was served. He said he did not know the soup was salty. The DM said when the kitchen ran low on a meal item the CK should start preparing more or delegate it to another staff member to get more food so the residents would not go without food items. The NHA said the facility was aware of the complaints of the food's palatability and that was the reason the facility experienced a lot of turnover in the kitchen. The NHA said with the current DM there have been improvements but the DM had only been in the facility for about a month. The NHA said the food was getting better and was going to continue to improve.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews the facility failed to ensure 10 (#12, #64, #4, #15, #41, #55, #7, #44, #18 and #129) of 17 residents with an order for a mechanically altered diet texture out of 46 sample residents received food and fluids prepared in a form designed to meet their needs per physician orders. Specifically, the facility failed to: -Provide Resident #12, #64, #4, #15, #41, #55, #7, #44 and #18 with the correct altered mechanical soft diet texture: and, -Provide Resident #129 with the correct altered pureed diet texture. Findings include: I. Professional reference The comparison of National Dysphagia Diet (NDD) and International Dysphagia Diet Standardization Initiative (IDDSI), reviewed July 2021, was retrieved on 12/29/24 from https://iddsi.org/IDDSI/media/images/CountrySpecific/UnitedStates/NDD-to-IDDSI-Implementation.pdf. It read in pertinent part, NDD of 2002 is being replaced by the IDDSI Framework, founded in 2013. This is the only professionally recognized and supported diet framework as of October 2021. NDD level three dysphagia advanced is now IDDSI soft and bite-sized level six. The NDD description stated bite-sized, soft, moist and not sticky. However, bite-sized guidelines were larger than the typical diameter of an air way. The IDDSI name of soft and bite-sized is more descriptive of what food consistency the kitchens should produce. The Soft and Bite-sized Framework, finalized January 2019, was retrieved on 12/29/24: https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/6_Soft_Bite_Sized_Adult_consumer_handout_30Jan2019.pdf It read in pertinent part, Level six, soft and bite-sized foods: -Soft, tender and moist, but with no thin liquid leaking or dripping; -Ability to bite off a piece of food is not required; -Ability to chew bite-sized pieces so that they are safe to swallow is required; -Bite-sized piece no bigger than one and a half centimeters by one and a half centimeters (half an inch by half an inch) in size; -Food can be mashed or broken down with pressure from a fork; and, -A knife is not required to cut this food. (continued on next page)

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Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Examples of soft and bite-sized food for adults: -Meat is cooked tender and chopped so pieces are no bigger than half an inch by half an inch lump size. If the meat cannot be served soft and tender, the meat needs to be served as minced and moist (chopped with a sauce); -Fish is cooked soft enough to break and serve pieces are no bigger than half an inch by half an inch; -Fruit is soft and chopped into pieces no bigger than half an inch by half an inch with any excess liquid drained. Do not use fibrous parts of the fruit; -Vegetables are steamed or boiled with the final cooked size no bigger than half an inch by half an inch. Stir-fried vegetables are too firm and are not suitable; -Cereal is served with pieces no bigger than half an inch by half an inch with their texture fully softened. Drain excess liquid before serving; -No regular bread due to a high choking risk; and, -Rice requires a sauce to moisten it and hold it together. Rice should not be sticky or gluey and should not separate into individual grains when cooked and served. Food characteristics to avoid are soup with pieces of food, cereal with milk, nuts, raw vegetables, dry cakes, bread, dry cereal, steak, pineapple, candies, marshmallows, raw carrot, raw apple, popcorn, peas, grapes, chicken or salmon skin, meat with gristle, overcooked oatmeal, lettuce, cucumber, uncooked baby spinach, crisp bacon, etc. The Pureed Framework, finalized January 2019, was retrieved on 1/2/5 from https://www.iddsi.org/images/Publications-Resources/PatientHandouts/English/Adults/4_pureed_adults_consumer_handout_30jan2019.pdf. It read in pertinent part, Level 4, pureed foods: -Are usually eaten with a spoon; -Do not require chewing; -Have a smooth texture with no lumps; -Hold shape on a spoon; -Fall off a spoon in a single spoonful when tilted; -Are not sticky; and, -Liquid (like sauces) must not separate from solids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Level 4 - Pureed Food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods only need the tongue to be able to move forward and back to bring the food to the back of the mouth for swallowing. It's important that puree foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. Pureed foods are best eaten using a spoon. Examples of foods to avoid: -Mixed thin and thick textures: Soup with pieces of food, cereal with milk; -Hard or dry food: nuts, raw vegetables (carrots, cauliflower, broccoli), dry cakes, bread, dry cereal; -Tough or fibrous foods: steak, pineapple; -Chewy: lollipops/candies/sweets, cheese chunks, marshmallows, chewing gum, sticky mashed potato, dried fruits, sticky foods: -Crispy; crackling, crisp bacon, cornflakes; -Crunchy food: Raw carrot, raw apple, popcorn: -Sharp or spiky: corn chips and crisps; -Crumbly bits: dry cake crumble, dry biscuits; -Pips, seeds: Apple seeds, pumpkin seeds, white of an orange; -Food with skins or outer shell: peas, grapes, chicken skin, salmon skin, sausage skin; -Foods with husks: corn, shredded wheat, bran; -Bone or gristle: chicken bones, fish bones, other bones, meat with gristle; -Round, long shaped food: sausage, grapes; -Sticky or gummy food: nut butter, overcooked oatmeal/porridge, edible gelatin, konjac containing jelly, sticky rice cakes; -Stringy food: beans, rhubarb; -Floppy foods: lettuce, cucumbers, uncooked baby spinach leaves; -Crust formed during cooking or heating: crust or skin that forms on food during cooking or after heating, for example, cheese topping, mashed potato; -Juicy food: where juice separates from the food piece in the mouth, for example watermelon; and, (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Visible lumps: Lumps in pureed food or yogurt. II. Facility policy The Therapeutic Diets policy, revised October 2017, was provided by the nursing home administrator (NHA) on 12/19/24 at 5:38 p.m. It read in pertinent part, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. The diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. A therapeutic diet must be prescribed by the resident's attending physician. A diet order should match the terminology used by the food and nutrition services department. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or alter the texture of a diet. If a mechanically altered diet is ordered the provider will specify the texture modification. Snacks will be compatible with the therapeutic diet. III. Facility diet manual for mechanical soft The Diet Manual, revised 2022, was provided by the NHA on 12/19/24 at 10:00 a.m. It read in pertinent part, Mechanical soft diet (dysphagia advanced level three, similar to IDDSI soft and bite-sized level six): this diet provides a texture modification of the regular diet for residents with mild oral and/or pharyngeal phase dysphagia. Foods must be soft, tender and moist with no thin liquid leaking or dripping from food. The ability to bite off a piece of food is not required. The ability to chew bite-sized pieces is required. Foods that are difficult to chew are chopped, ground, shredded or cooked to make them easier to chew and swallow. General guidelines: Ease of chewing may be increased by mashing, chopping or slenderizing; pour syrups, honey or juices over bread products such as pancakes, french toast, waffles and muffins; serve soft crackers and other breads in soup; use gravies, broths and sauces on ground meats, poultry and other dishes; well-cooked, soft (or mashed) vegetables without skin, mashed potatoes and vegetable juices are well-tolerated; there are two divisions of mechanical soft chopped half-inch pieces and ground eight-inch pieces. Pay attention to specific differentiations in how to prepare food for both. Avoid vegetables that are raw or crunchy, vegetables with skin or husks like peas and corn, no stringy or floppy vegetables like string beans, celery, lettuce, cucumber and baby spinach leaves; and potatoes with skins or crispy fried potatoes. Protein must be very tender, small pieces and chopped to half-inch pieces moistened with gravy or sauce. Avoid tough or dry meats, poultry or fish. IV. Resident #12 (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #12, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy (neurological disorder), malignant neoplasm of floor of mouth (oral cancer), dysphagia (difficulty swallowing) oral and oropharyngeal phase and alcohol dependence with alcohol-induced persisting dementia. The 10/7/24 minimum data set (MDS) assessment revealed Resident #12 was not assessed for a brief interview for mental status (BIMS). The assessment indicated Resident #12 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:30 p.m., the cook (CK) served Resident #12 regular unthickened Italian Wedding soup with chopped vegetables in the soup and a regular dinner roll. Resident #12's meal ticket revealed the resident needed thickened Italian wedding soup and a soaked dinner roll. -The facility failed to serve the resident thickened soup with carrots no bigger than half-inch by half-inch in the soup. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #12's December 2024 CPO revealed a physician's order for a mechanical soft textured diet, ordered 11/1/24. Resident #12's dental care plan, initiated 3/19/24, revealed the resident was at risk for alteration of oral hygiene, mouth and or teeth due to a history of oral cancer. Interventions included assisting the resident with coordinating dental care, providing the resident with his diet as ordered and providing oversight management to the resident's care. V. Resident #64 A. Resident status Resident #64, age greater than 65, was admitted [DATE]. According to the December 2024 CPO, diagnoses included Alzheimer's disease with late onset, dysphagia oral and oropharyngeal phase, cognitive communication deficit and dementia. The 12/6/24 MDS assessment revealed Resident #64 had a severe cognitive impairment with a BIMS score of zero out of 15. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment indicated Resident #64 required substantial or maximal assistance with eating and was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:59 p.m., Resident #64 ordered the main entree, which was chicken cordon bleu. The cook (CK) served the resident a chicken cordon bleu that was cut into one-inch pieces and a whole regular roll. -The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch sized pieces. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #64's December 2024 CPO revealed a physician's order for a mechanical soft textured diet, ordered 10/17/24. Resident #64's nutrition care plan, initiated 9/19/24, revealed the resident was on a regular diet. Interventions included occupational therapy screens and adaptive equipment as needed, providing and serving his diet as ordered, the registered dietitian (RD) to evaluate and make diet change recommendations and referring to the resident's likes and dislikes. -However, the facility failed to update Resident #64's care plan when he was ordered a mechanical soft texture change on 10/17/24. VI. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia, dysphagia oropharyngeal phase and Alzheimer's disease with late onset. The 10/30/24 MDS assessment revealed Resident #4 was unable to participate in the BIMS assessment due to rarely being understood. The staff assessment revealed Resident #4 had short and long-term memory problems. The resident's daily decision-making skills were severely impaired. The assessment indicated Resident #4 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 6:04 p.m., the CK served Resident #4 chicken cordon bleu cut into one-inch pieces, and a regular roll cut into bite-sized pieces. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch size pieces. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #4's December 2024 CPO revealed a physician's order for a mechanical soft textured diet, ordered 12/13/23. Resident #4's nutrition care plan, revised on 4/30/24, revealed the resident was easily distracted during meals. Interventions included providing and serving diet as ordered and referring to the resident's likes and dislikes. VII. Resident #15 A. Resident status Resident #15, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia and dysphagia oropharyngeal phase. The 10/8/24 MDS assessment revealed Resident #15 was unable to participate in the BIMS assessment due to rarely being understood. The staff assessment revealed Resident #15 had short and long-term memory problems. The resident's daily decision-making skills were severely impaired. The assessment indicated Resident #15 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:09 p.m. the CK served Resident #15 chicken cordon bleu cut into one-inch pieces, a regular dinner roll was cut into bite-sized pieces and a bowl of regular Italian wedding soup. -The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch sized pieces. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. -The facility failed to serve the resident soup with carrots no bigger than half-inch by half-inch in the soup. C. Record review Review of Resident #15's December 2024 CPO revealed a physician's order for a mechanical soft textured diet, ordered 8/2/23. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15's nutrition care plan, revised 11/13/23, revealed the resident was on a mechanical soft diet. Pertinent interventions included having the resident eat at the assist table in the dining room, offering the resident brunch when she slept through breakfast, providing and serving her diet as ordered and referring to her likes and dislikes. VIII. Resident #41 A. Resident status Resident #41, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia, dysphagia oropharyngeal phase and senile degeneration of the brain. The 12/5/24 MDS assessment revealed Resident #41 had severe cognitive impairment with a BIMS score of one out of 15. The assessment indicated Resident #41 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:14 p.m. the CK served Resident #41 regular Italian Wedding soup with a regular roll cut into bite- sized pieces. Resident #41's meal ticket revealed the soup needed to be thickened and the roll needed to be soaked. -The facility failed to serve the resident thickened soup with carrots no bigger than half-inch by half-inch in the soup. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #41's December 2024 CPO revealed a physician's order for a mechanical soft textured diet with extra gravy or sauce at each meal, ordered 5/6/23. Resident #41's nutrition care plan, revised 11/22/24, revealed the resident was on a mechanical soft diet. Interventions included providing and serving her diet as ordered and referring to her likes and dislikes. IX. Resident #55 A. Resident status (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included seizures, cognitive communication deficit and dysphagia oropharyngeal phase. The 9/17/24 MDS assessment revealed Resident #55 had severe cognitive impairment with a BIMS score of three out of 15. The assessment indicated Resident #55 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 6:05 p.m. the CK served Resident #55 chicken cordon bleu cut into one-inch pieces with no sauce and a regular roll cut into bite-sized pieces. -The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch sized pieces and serve it with extra gravy or sauce. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #55's December 2024 CPO revealed a physician's order for a mechanical soft textured diet with extra gravy or sauce at each meal and nectar thick liquids, ordered 12/13/24. Resident #55's nutrition care plan, revised 12/18/24, revealed the resident was on a mechanical soft diet. Interventions included providing and serving his diet as ordered and referring to his likes and dislikes. X. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included epilepsy, dementia and dysphagia oropharyngeal phase. The 10/16/24 MDS assessment revealed Resident #7 had a mild cognitive impairment with a BIMS score of 12 out of 15. B. Observations On 12/18/24 at 5:25 p.m. the CK served Resident #7 chicken cordon bleu cut into one-inch pieces and a roll cut into bite-sized pieces. -The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch sized pieces. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #7's December 2024 CPO revealed a physician's order for a mechanical soft textured diet, ordered 10/24/24. Resident #7's nutrition care plan, revised 7/15/24, revealed the resident was on a mechanical soft diet. Interventions included providing and serving her diet as ordered and referring to her likes and dislikes. XI. Resident #44 A. Resident status Resident #44, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included a mild cognitive impairment and dysphagia oropharyngeal phase. The 10/25/24 MDS assessment revealed Resident #44 was cognitively intact with a BIMS score of 15 out of 15. The assessment indicated Resident #44 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:28 p.m. the CK served Resident #44 two portions of chicken cordon bleu cut into one-inch pieces and two regular rolls cut into bite-sized pieces. -The facility failed to cut the resident's chicken into no bigger than half-inch by half-inch sized pieces. -The facility failed to serve the resident soaked dinner rolls that were very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #44's December 2024 CPO revealed a physician's order for a mechanical soft textured diet and double portions, ordered 7/20/22. Resident #44's nutrition care plan, revised 4/22/24, revealed the resident was on a mechanical soft diet. Interventions included providing double portions with each meal, providing and serving his diet as ordered and referring to his likes and dislikes. XII. Resident #18 A. Resident status (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included heart failure and dysphagia oropharyngeal phase. The 12/10/24 MDS assessment revealed Resident #18 was unable to participate in the BIMS assessment due to rarely being understood. The staff assessment revealed Resident #18 had short and long-term memory problems. The resident's daily decision-making skills were severely impaired. The assessment indicated Resident #18 was on a mechanically altered diet requiring a change in the texture of foods. B. Observations On 12/18/24 at 5:54 p.m. the CK served Resident #18 a bowl of regular Italian wedding soup and a whole regular roll. -The facility failed to serve the resident thickened soup with carrots no bigger than half-inch by half-inch in the soup. -The facility failed to serve the resident a soaked dinner roll that was very moist and soaked through the entire thickness of the roll. C. Record review Review of Resident #18's December 2024 CPO revealed a physician's order for a mechanical soft textured diet and nectar thick liquids, ordered 7/12/24. Resident #18's nutrition care plan, revised 3/7/24, revealed the resident was on a mechanical soft diet. Interventions included providing and serving her diet as ordered and referring to her likes and dislikes. XIII. Resident #129 A. Resident status Resident #129, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included Alzheimer's disease with late onset and dementia. The 12/18/24 MDS assessment revealed Resident #129 had a severe cognitive impairment with a BIMS score of zero out of 15. B. Observation On 12/18/24 at 6:12 p.m., the CK served Resident #129 a bowl of watery pureed Italian wedding soup. -The facility failed to serve the resident pureed soup in a thick, mashed potato-like consistency. C. Record review (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #129's December 2024 CPO revealed a physician's order for a pureed textured diet, ordered 12/14/24. Resident #129's nutrition care plan, initiated 12/16/24, revealed the resident was on a pureed diet. Interventions included providing and serving the resident her diet as ordered and referring to her likes and dislikes. XIV. Staff interviews The dietary manager (DM) was interviewed on 12/18/24 at 4:45 p.m. The DM said residents who were on a mechanical soft textured diet were able to eat bread that was wet and cut into bite-sized pieces. The CK was interviewed on 12/18/24 at 5:13 p.m. The CK said the residents were able to eat bread if the bread was soft and cut into bite-sized pieces. He was unaware how big or small the pieces needed to be. Dietary aide (DA) #1 was interviewed on 12/18/24 at 5:59 p.m. DA #1 said the residents who received whole rolls did not like having their rolls cut up and that was how he always served the residents no matter what their diet textures were. The DM and the NHA were interviewed together on 12/19/24 at 6:11 p.m. The DM said he was unaware the facility had a diet manual that explained the difference in textures for mechanically altered diets. The NHA said she provided the DM with the diet manual. The DM said he was going to ensure he trained his staff on diet textures. He said if a resident was served the wrong diet texture, the resident could choke and the facility wanted to prevent that. The DM said the chicken needed to be cut in half-inch by half-inch pieces The DM said the CK should have soaked the dinner rolls

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48412 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.conditions in the kitchen. Specifically, the facility failed to: -Ensure the staff medications were not stored in the walk-in refrigerator with resident food; -Ensure the staff wore a beard net while preparing and serving meals; and, -Ensure the air vent above the food service line was free of dust and dirt. Findings include: I. Failure to ensure staff medications were not stored in the walk-in refrigerator A. Professional reference The Colorado Retail Food Establishment Rules and Regulations, Chapter 7-5, effective 3/16/24, was retrieved on 12/29/24, revealed in pertinent part, Medicines belonging to employees that require refrigeration and are stored in a food refrigerator shall be stored in a package or container and kept inside a covered, leakproof container that is identified as a container for the storage of medicines. B. Observations During the initial tour of the main kitchen on 12/16/24 at 9:57 a.m. the walk-in refrigerator had a plastic bag on the top shelf next to the resident's food. Inside the plastic bag was an insulin pen and glucose test strips. The medication and bag were not labeled. C. Staff interviews The dietary manager (DM) was interviewed on 12/16/24 at 1:00 p.m. The DM said the insulin pen belonged to a dining staff member. The DM said he put the insulin pen in the walk-in refrigerator because he had nowhere else to store it. The DM said he was not aware medications could not be stored in the refrigerator with food. II. Ensure kitchen staff wore appropriate hair restraints while preparing and serving food A. Professional reference (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Colorado Retail Food Establishment Regulations, Chapter 2-21, effective 3/16/24, were retrieved on 12/29/24, revealed in pertinent part, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. B. Observations During a continuous observation on 12/16/24, from 11:37 a.m. to 12:33 p.m., the following was observed: At 11:37 a.m., dietary aide (DA) #1 was at the kitchen serving window without a beard net or hair net on. His facial hair was approximately half an inch long. At 11:59 a.m., two unidentified male staff were in the kitchen without beard nets on. The cook (CK) had a beard that was roughly two inches long. At 12:00 p.m., an unidentified maintenance worker was in the kitchen walking around the food preperation area while food was being served without a beard net on. His beard was down to his chest, approximately six to seven inches long. During a continuous observation on 12/18/24, from 4:30 p.m. to 6:15 p.m., the following was observed: From 4:30 p.m. to 6:15 p.m. DA #1 was not wearing a beard net and his facial hair was longer approximately half an inch long. At 5:59 p.m. the CK returned to the kitchen and did not have his beard net on. His beard was approximately two inches long. C. Staff interviews The DM was interviewed on 12/16/24 at 1:00 p.m. The DM said he was informed beard nets were only required if the facial hair was longer than one-quarter of an inch. He said he never thought about having the kitchen staff wear beard nets. The DM was interviewed again on 12/19/24 at 6:11 p.m. The DM said he told the staff they needed to wear beard nets in the kitchen and was not sure why some of the staff continued to not wear anything. He said the staff member that had a long beard was a staff member from the maintenance department. The DM said he was not aware that the maintenance staff needed to wear a beard net in the kitchen too. III. Ensure the kitchen vents were free of dust and dirt A. Professional reference (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Colorado Retail Food Establishment Regulations, Chapter 6-3, effective 3/16/24, were retrieved on 12/29/24, revealed in pertinent part: Attachments to walls and ceilings such as light fixtures, mechanical room ventilation system components, vent covers, wall mounted fans, decorative items and other attachments shall be easily cleanable. Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt and other materials. B. Facility policy and procedure The Sanitation policy, revised November 2022, was provided by the nursing home administrator (NHA) on 12/19/24 at 5:38 p.m. and read in pertinent part, All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. C. Observations During the initial tour of the kitchen on 12/16/24 at 9:57 a.m. the air vent above the stove and food service line was covered in black dust. Some areas were thick and built up more than other areas. During the meal observation on 12/18/24 at 4:30 p.m. the air vent above the stove and food service line remained covered in black dust. Some of the areas were thick and built up more than other areas. The air conditioning system was on and was blowing the black dust around. D. Staff interviews The DM was interviewed on 12/19/24 at 6:11 p.m. The DM said the air conditioning was not supposed to be on during meal service. He said he had not realized the vent was covered in thick, black dust. The DM said he was going to get the air vent cleaned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to implement an effective water management plan. Findings include: I. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, last reviewed 3/15/24, was retrieved on 12/31/24 from https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html It read in pertinent part, Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (degrees Fahrenheit) or 60 C (degrees Celsius). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible. Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 F, 25-45 C). Legionella may grow at temperatures as low as 68 F (20 C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Legionella Water Management Program policy and procedure, dated 6/26/23, was provided by the maintenance director (MTD) on 12/17/24 at 2:03 p.m. It documented in pertinent part, Dead run: flush and drain, if possible. Ideally, remove dead legs or redesign to allow for water recirculation, along with unused equipment and water lines from the system. Eliminate or minimize the use of rubber, plastic and silicone gaskets in the plumbing system. These materials may serve as growth substrates for bacteria, including legionella and other pathogenic microbes. Location: Various locations throughout the building. Frequency: Biannual and ongoing projects . -However, the CDC recommended that all dead legs and low flow piping runs should be flushed at least weekly to prevent the growth and spread of legionella (see professional reference above). Risk factor: Electronic and manual faucets: visually inspect for biofilm, scale, dirt, and debris buildup and clean with mild biocide such as vinegar, acidic cleaner or other cleaner Location: All units. Frequency: weekly, 25% of fixtures on a rotational basis . -However, the CDC recommended that all dead legs and low flow piping runs should be flushed at least weekly to prevent the growth and spread of legionella (see professional reference above). Water systems: little-used outlets. Flush for several minutes and until temperature stabilizes and is comparable to supply water. Have a flush program defined in the water management plan by the team. The Housekeeping Cleaning procedure, not dated, was provided by the MTD on 12/17/24 at 4:24 p.m. It documented that housekeeping staff flushed toilets daily. C. Record review The water management maintenance logs were provided by the MTD on 12/17/24 at 3:14 p.m. The maintenance logs documented the facility tested for legionella on 11/6/24 which was negative. The maintenance logs documented the maintenance department was conducting weekly flushing for five minutes and checking water temperatures for many locations throughout the building which included the laundry room sink, boiler room mixing valve, kitchen sinks, therapy room sink, two staff bathrooms, both bathing room tubs and sinks, the salon sink, the basement bathroom, and the basement hot water mixing valve. -The facility failed to document when empty resident rooms had been appropriately flushed to prevent the growth of legionella. On 12/17/24 at 5:12 p.m., the nursing home administrator (NHA) documented that two resident rooms had been unoccupied for seven contiguous days or more in the last 60 days. The NHA documented one of those unoccupied rooms had been vacant for seven contiguous days on two separate occasions. -The water management plan failed to document when empty resident rooms had low flow piping runs and lead legs flushed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Observations Housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER] on 12/19/24 at 12:24 p.m. During the room cleaning, the sink faucet was not turned on or flushed. D. Staff interviews The MTD was interviewed on 12/17/24 at 4:07 p.m. The MTD said she had taken a legionella water management class previously and understood how to prevent the growth of legionella. The MTD said she started in this role in October 2024. The MTD said the water management plan was not hers and she did not contribute to forming the water management plan. The MTD said a few resident rooms were chosen each month to be flushed. She said not all resident rooms were flushed every month because rooms were chosen on a rotational basis. The MTD said all of the toilets were flushed daily as part of resident use and daily cleaning by housekeeping. The MTD said dead legs and low flow piping runs were flushed biannually. The MTD was interviewed again on 12/17/24 at 4:27 p.m. The MTD said she was told to flush the resident's rooms monthly. The MTD said that housekeepers flush sinks daily as part of their cleaning, but there was no specific documentation that the sinks had been flushed to prevent the growth of legionella. The MTD said the housekeepers documented the type of cleaning that was performed and this was sufficient to prove that sinks had been flushed. The MTD and the regional maintenance director (RMD) were interviewed together on 12/17/24 at 5:06 p.m. The MTD and the RMD said that flushing dead legs and low flow piping runs biannually was sufficient to prevent the growth and spread of legionella. The RMD said if the facility were to create a new dead leg it would be managed in accordance with the written water management plan. HK #1 was interviewed on 12/19/24 at 12:31 p.m. HK #1 said she had worked at the facility for several years. HK #1 said she did not turn on the sink when she cleaned room [ROOM NUMBER] today (12/19/24). HK #1 said she received training on how to clean resident rooms, but she did not receive education or instruction to flush sinks while she cleaned rooms. HK #1 said she normally flushed the toilets during every room clean.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal and influenza vaccinations for two (#28 and #43) of five residents out of 46 sample residents. Specifically, the facility failed to offer pneumococcal vaccinations to Resident #28 or Resident #43. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2022, retrieved on 1/2/25, from: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, in pertinent part, Routine vaccination-pneumococcal: For those ages 19 to 64 with an additional risk factor or another indication was: One (1) dose PCV15 (pneumococcal 15-valent conjugate vaccine PCV15 Vaxneuvance) followed by PPSV23 (pneumococcal 23-valent polysaccharide vaccine PPSV23 Pneumovax 23)or one (1) dose PCV20 (pneumococcal 20-valent conjugate vaccine PCV20 Prevnar 20). For those over the age of 65 who meet age requirements and lack documentation of vaccination, or lack evidence of past infection was: One (1) dose PCV15 followed by PPSV23 or one (1) dose PCV20. Special situations: Age 19-[AGE] years with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: One (1) dose PCV15 or one (1) dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. Note: Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus (HIV), Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies. Note: Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF (cerebral spinal fluid) leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies. II. Resident #28 A. Resident status (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28, over the age of 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, gastroesophageal reflux disease (GERD) and benign prostatic hyperplasia (BPH). The 10/29/24 minimum data set (MDS) assessment revealed the resident had no cognitive impairments with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident had not received the pneumonia vaccine. The assessment documented the facility did not offer the pneumonia vaccine to the resident. B. Record review -Review of the resident's electronic medical record (EMR) did not reveal documentation of the most recent pneumonia vaccine offered or received by the resident. Documentation provided by the nursing home administrator (NHA) on 12/18/24 at 10:22 a.m. documented that Resident #28 had been offered the pneumonia vaccine on 12/18/24 (during the survey). -The facility failed to offer Resident #28 a pneumococcal vaccination prior to 12/18/24. III. Resident #43 A. Resident status Resident #43, over the age of 65, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia, hypertension (high blood pressure) and depression. The 10/26/24 MDS assessment revealed the resident had severe cognitive impairment and was unable to complete a BIMS assessment because she was rarely understood. The assessment documented the resident received a pneumococcal vaccination on 10/13/24. -However, there was no documentation in the resident's EMR to indicate the resident received a pneumococcal vaccination on 10/13/24 or that a vaccination consent had been obtained prior to 12/18/24 (see record review below). B. Record review Review of Resident #43's EMR revealed the resident received a Prevnar 13 pneumococcal vaccination on 8/22/18. -There was no documentation to indicate the resident had received an updated pneumococcal vaccination prior to 12/18/24 (see below). Documentation provided by the NHA on 12/18/24 at 10:22 a.m. documented that Resident #43 had been offered the pneumonia vaccine on 12/18/24 (during the survey). -The facility failed to offer Resident #43 a pneumococcal vaccination prior to 12/18/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews The infection preventionist (IP) was interviewed on 12/19/24 at 12:59 p.m. The IP said she had been in her role for a few months and only gained access to the state immunization system in November 2024. The IP said the normal process for the facility was to go through all residents' vaccination consents and declinations at the same time as influenza and COVID-19 immunizations in October of each year. The IP said Resident #28 and Resident #43 were not offered a pneumococcal immunization before 12/18/24. The IP said Resident #28 and Resident #43 should have had a pneumococcal immunization offered to them prior to 12/18/24 The director of nursing (DON) was interviewed on 12/19/24 at 4:51 p.m. The DON said vaccinations should be offered to residents according to the recommendations of the CDC. The DON said Resident #28 and Resident #43 should have been offered a pneumococcal vaccination prior to 12/18/24.