

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Wheatridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2920 Fenton St Wheat Ridge, CO 80214	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure three (#17, #51 and #7) of six residents were free from chemical restraints were receiving the least restrictive approach for their needs out of 32 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #17's behavior care plan had resident specific non-pharmacological care approaches; -Document consistent behaviors for Resident #17, Resident #51 and Resident #7 to justify the continued use of psychotropic medications; and, -Document resident specific care approaches, to include medication specific target behaviors and person-centered interventions for Resident #51 and Resident #7's psychotropic medications. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Psychopharmacological policy, dated 3/10/23, was provided by the regional clinical resource (RCR) on 6/16/25 at 3:56 p.m. It read in pertinent part,</p> <p>The care plan will include the resident's focus and target behaviors for the medication. Realistic and measurable goals will be utilized and approaches will include alternatives to psycho-pharmacological drug use.</p> <p>The plan of care must include behavior interventions and medication monitoring/dosage reduction if appropriate. Considerations should be given to potential underlying causes of behavior symptoms to assure appropriate treatment.</p> <p>Licensed nurses and additional staff will monitor and document any targeted behaviors that occur. These behaviors will be documented on one or more of the following: electronic medical record, progress notes, or on a Risk Management Incident Report.</p> <p>II. Resident #17</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. Resident status</p> <p>Resident #17, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included bipolar disorder (mental illness), anxiety, depression, post traumatic stress disorder (PTSD) and vascular dementia.</p> <p>The 6/2/25 minimum data set (MDS) assessment documented the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. Resident #17 required one-person staff assistance with toileting and dressing. She ambulated independently.</p> <p>The MDS assessment indicated the resident did not have any behaviors during the assessment look back period.</p> <p>B. Record review</p> <p>The depression care plan, revised 12/3/24, revealed Resident #17 took antidepressant medications related to depression. An intervention, initiated 6/13/23, included monitoring the resident for hallucinations, delusions, social isolation and insomnia.</p> <p>-Review of the resident's depression care plan revealed there were no person-centered non-pharmological interventions for the resident's antidepressant medication use.</p> <p>The mood care plan, revised 12/3/24, revealed Resident #17 took antipsychotic medications associated with the diagnosis of vascular dementia with behaviors. The care plan documented her identified target behaviors were verbal and physical aggression towards others. Pertinent interventions included medications were to be reviewed quarterly and as indicated and attempts to reduce the dosage were to be made when clinically indicated (4/16/25).</p> <p>-Review of the resident's mood care plan revealed there were no person-centered non-pharmological interventions for the resident's antipsychotic medication.</p> <p>The behavior care plan, revised 4/7/25, revealed Resident #17 had the potential to be physically aggressive towards others related to dementia with behaviors with a history of throwing items. Pertinent interventions included providing the resident opportunities for positive interaction, stopping and speaking with her, discussing her behavior with her if it was inappropriate or unacceptable, approaching the resident in a calm manner, diverting attention and removing the resident to an alternative location (9/1/23).</p> <p>Review of Resident #17's June 2025 CPO revealed the following physician's orders:</p> <p>Monitor behaviors for antidepressant use. Document number of episodes of target behavior, interventions attempted and effectiveness. Target behavior 1. Isolation 2. Anger 3. Hallucinations. Intervention: a. Redirection b. One-on-one c. Diversional activity d. Offer to call family/friends e. Other-document in progress notes, ordered on 9/24/24.</p> <p>Risperdal (antipsychotic medication) 1 milligram (mg), take one tablet at bedtime for dementia with behaviors, ordered on 1/7/25.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The comprehensive care plan failed to identify any medication specific target behaviors or person-centered interventions for the usage of the resident's mood stabilizing medication.</p> <p>Review of Resident #51's June 2025 CPO revealed the following physician's orders:</p> <p>Aripiprazole (antipsychotic medication) 10 mg, give one tablet once a day for bipolar disorder, ordered 10/1/24.</p> <p>Monitor behaviors for antipsychotic use. Document number of episodes of target behavior, interventions attempted, and effectiveness. Target behavior 1. Isolation 2. Hallucinations Intervention: a. Redirection. b. One-on-one c. Activity d. Low stimulating environment e. Offer toileting f. Offer snacks g. Offer fluids h. Assess for pain i. Other-document in progress notes, ordered 10/1/24.</p> <p>Depakote (mood stabilizer) 500 mg. Give one tablet in the morning for bipolar disorder, ordered 4/10/25.</p> <p>Depakote 250 mg. Give one tablet at bedtime for bipolar disorder, ordered 4/10/25.</p> <p>-The behavior monitoring physician's order failed to include identified behaviors of mania/increased energy, racing thoughts, poor sleep, rapid speech, hyper focus, depressive statements and psychosis (see care plan above).</p> <p>-Resident #51 did not have behavior monitoring for the mood stabilizer medication.</p> <p>Review of Resident #51's MARs and TARs from 4/1/25 to 6/12/25 revealed the following:</p> <p>The March 2025 (3/1/25 to 3/31/25) MAR/TAR revealed there was no documentation to indicate Resident #51 exhibited behaviors during the month.</p> <p>The April 2025 (4/1/25 to 4/30/25) MAR/TAR revealed there was no documentation to indicate Resident #51 exhibited behaviors during the month.</p> <p>The May 2025 (5/1/25 to 5/31/25) MAR/TAR revealed there was no documentation to indicate Resident #51 exhibited behaviors during the month.</p> <p>The June 2025 (6/1/25 to 6/12/25) MAR/TAR revealed there was no documentation to indicate Resident #51 exhibited behaviors during the month.</p> <p>Review of Resident #51's EMR from 3/1/25 to 6/12/25 revealed the following progress notes:</p> <p>A psychological GDR note, dated 3/4/25, revealed that Resident #51 had reported increased ruminating thoughts and mania. The note documented the staff attributed the resident's elevated mood to the recent start of medications for Parkinson's disease.</p> <p>A psychological follow-up note, dated 3/11/25, revealed Resident #51 reported depression and racing thoughts, feelings of loneliness and variations in sleep patterns.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly social services evaluation note, dated 3/25/25, revealed Resident #51 reported racing thoughts on a consistent basis.</p> <p>-However, no changes were made to Resident #51's behavior monitoring physician's order to include racing thoughts or the person-centered non pharmacological interventions that worked for her racing thoughts.</p> <p>A psychosocial social services note, dated 4/2/25, revealed Resident #51 had been presenting with instances of extreme agitation over the previous week. Additionally, Resident #51 had reported challenges with sleep. The resident's sister advised the facility that poor sleep, rapid speech, hyper fixation and racing thoughts were indicators of mania for Resident #51. Resident #51 endorsed to the social services director (SSD) that she was experiencing these symptoms. The resident's medication was to be reviewed.</p> <p>A psychological follow-up note, dated 4/9/25, revealed Resident #51 reported to the psychiatric nurse practitioner (NP) that she had been experiencing mania with mood elevation.</p> <p>A physician's visit note, dated 4/18/25, revealed Resident #51 had been reporting increased rumination of thoughts, poor sleep and agitation.</p> <p>A psychological follow-up note, dated 4/23/25, revealed that Resident #51 continued to report manic episodes with difficulty sleeping and episodes of anxiety.</p> <p>-Review of Resident #51's EMR did not reveal any further progress notes revealing behavior monitoring and non-pharmacological interventions were attempted for Resident #51's manic episodes, poor sleep, rapid speech, hyper fixation and racing thoughts between 3/4/25 and 6/12/25.</p> <p>A review of Resident #51's psychoactive pharmacological management meeting minutes, dated 5/6/25, failed to reveal Resident #51 was on an antipsychotic medication (Aripiprazole). The only medication indicated as being reviewed was the resident's Depakote. Target behaviors indicated for the Depakote were periods of mania/increased energy, racing thoughts, poor sleep, rapid speech, hyper focus on change, self-isolation, periods of depressive statements and psychosis. The medical provider's response revealed the recent increase of Depakote was due to witnessed mania episodes from the staff in which redirection and conversations with her family did not alleviate (Resident #51's) mood.</p> <p>-However, review of the resident's EMR did not reveal documentation that indicated the nursing staff had witnessed mania episodes.</p> <p>IV. Resident #7</p> <p>A. Resident status</p> <p>Resident #7, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included schizophrenia (mental illness) and anxiety.</p> <p>The 4/28/25 MDS assessment documented the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. Resident #7 was independent with his ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The MDS assessment indicated the resident had not had any behaviors during the assessment look back period.</p> <p>B. Record review</p> <p>The mood care plan, revised 4/19/24, revealed Resident #7 took medications associated with the diagnosis of schizophrenia. The care plan identified the resident's target behaviors: auditory hallucinations/voices, paranoia, anxiety/rapid and shallow breathing. Interventions included developing a program of activities that was meaningful and of interest to the resident, providing affirmations when the resident converses with others and providing active listening when he became tearful (4/19/24).</p> <p>The psychotropic medication care plan, revised 5/29/24, revealed Resident #7 took antipsychotic medications associated with the diagnosis of schizophrenia. Interventions, dated 6/6/25, included target behaviors of verbal aggression and agitation with interventions of redirection, one-on-one, activity, low stimulating environment, offer toileting, offer snack, offer fluids, and assess for pain.</p> <p>The behavior care plan, revised 2/26/25, revealed that Resident #7 had behaviors related to schizophrenia with a history of removing clothing, displaying physical and verbal aggression towards staff, rubbing hand sanitizer on his head, and making sexually inappropriate comments to other residents. Interventions included providing the resident opportunities for positive interaction, stopping and speaking with him and discussing his behavior with him if inappropriate or unacceptable (4/11/24).</p> <p>Review of Resident #7's June 2025 CPO revealed the following physician's orders:</p> <p>Monitor behaviors for antipsychotic use. Document number of episodes of target behavior, interventions attempted, and effectiveness. Target behavior 1. Isolation 2. Hallucinations Intervention: a. Redirection b. One-on-one c. Activity d. Low stimulating environment e. Offer toileting f. Offer snacks g. Offer fluids h. Assess for pain i. Other-document in progress notes, ordered on 9/24/24 and discontinued on 6/6/25.</p> <p>Risperdal 3 mg, give one once a day for schizophrenia, ordered 3/5/25.</p> <p>Monitor behaviors for antipsychotic use. Document number of episodes of target behavior, interventions attempted, and effectiveness. Target behavior 1. Verbal aggression 2. Agitation Intervention: a. Redirection b. One-on-one c. Activity d. Low stimulating environment e. Offer toileting f. Offer snacks g. Offer fluids h. Assess for pain i. Other-document in progress notes, ordered 6/6/25.</p> <p>-The behavior monitoring physician's order, dated 9/24/24 and 6/6/25, had different behaviors with the same non-pharmological interventions that were not specific to Resident #7.</p> <p>-The behavior monitoring physician's order failed to include identified behaviors of paranoia, removing clothing, physical aggression, inappropriately using hand sanitizer and sexual comments towards other residents (see care plan above).</p> <p>Review of Resident #7's MARs and TARs from 4/1/25 to 6/12/25 revealed the following:</p> <p>The April 2025 (4/1/25 to 4/30/25) MAR/TAR revealed there was no documentation to indicate Resident #7 exhibited behaviors during the month.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The May 2025 (5/1/25 to 5/31/25) MAR/TAR revealed there was no documentation to indicate Resident #7 exhibited behaviors during the month.</p> <p>The June 2025 (6/1/25 to 6/12/25) MAR/TAR revealed there was no documentation to indicate Resident #7 exhibited behaviors during the month.</p> <p>Review of Resident #7's EMR from 3/1/25 to 6/12/25 revealed the following progress notes:</p> <p>A psychological GDR note, dated 3/4/25, revealed staff reported Resident #7 had increased paranoia, pressured speech, delusions and yelling at other residents. The resident's Risperdal had been increased from 2 mg daily to 3 mg daily.</p> <p>A psychological follow-up note, dated 3/4/25, revealed documentation the psychiatric NP reviewed documentation from 2/24/25 that indicated Resident #7 had increased agitation. The interventions of giving the resident space, one-on-one intervention and reassurance were only mildly effective. The note documented that on 2/25/25, Resident #7 had been loudly expressing personal prejudices towards staff. The staff attempted to provide education to the resident on appropriate behavior but he remained with an elevated mood. During the psychiatric NP assessment of Resident #7 on 3/4/25, he was calm, pleasant and cooperative. The resident denied anxiety, depression, or experiencing hallucinations.</p> <p>A psychological GDR note, dated 4/1/25, revealed that Resident #7's Risperdal had been increased the previous month (March 2025) with some improvement, although staff reported ongoing behaviors of the resident being combative and threatening during care.</p> <p>A psychological follow-up note, dated 4/9/25, revealed the staff reported that Resident #7 could become angry and forceful at times, getting into the staff members faces with inconsistencies in communication status and erratic sleep patterns.</p> <p>A behavior note, dated 4/9/25, revealed that Resident #7 displayed physical aggression towards staff but was redirectable.</p> <p>-However, the method of redirection was not indicated on the resident's care plan.</p> <p>A behavior note, dated 4/19/25, revealed certified nurse aide (CNA) #3 reported to nursing that Resident #7 had been pulling his brief down and urinating in front of the receptionist's desk and had been difficult to redirect, requiring the assistance of other staff.</p> <p>A quarterly social services evaluation note, dated 4/28/25, revealed that Resident #7's mood and behaviors had been stable over the last three-month period.</p> <p>-The note did not reflect the behaviors displayed over the last three months and the necessity to increase Resident #7's antipsychotic medication as a result.</p> <p>A review of Resident #7's psychoactive pharmacological management meeting minutes, dated 4/1/25, revealed the resident's mood had been stable after medication was increased, however staff still reported agitation at times related to care. The person-centered non pharmacological interventions tried and if effective or not were not discussed.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>V. Staff interviews</p> <p>CNA #6 was interviewed on 6/10/25 at 1:30 p.m. CNA #6 said she started working at the facility three days prior to the interview. She said she thought resident specific behaviors and person-centered interventions were in the individual resident's care plan but she did not know how to access the care plan.</p> <p>CNA #5 was interviewed on 6/11/25 at 1:11 p.m. CNA #5 said Resident #51 did not have any behaviors. CNA #5 was not aware of any signs or symptoms of mania or non-pharmacological interventions for Resident #51.</p> <p>CNA #5 said Resident #17 had behaviors of wandering the hallways at night and sleeping all day. CNA #5 said Resident #17 would become angry if staff woke her up to perform care but if staff offered her an ice cream or a soda, Resident #17 would cooperate. CNA #5 said management would tell the staff what behaviors and interventions they wanted the staff to observe or use for residents. She said the CNAs documented in the CNA charting but there was only a list of generic, template behaviors and interventions available in the CNA charting and if the appropriate behavior or intervention were not on the template, the CNA would tell the nurse so the nurse could make a progress note.</p> <p>Registered nurse (RN) #2 was interviewed on 6/11/25 at 1:26 p.m. RN #2 said she did not know Resident #17, Resident #51 or Resident #7 very well but said nurses documented behaviors in the progress notes as a behavior note. RN #2 said resident behaviors, interventions to monitor and to use were in a behavior monitoring order and showed up on the MAR. She said she did not think the behavior monitoring physician's orders could be customized and that was why all the residents had similar non-pharmacological interventions. RN #2 said she would look at the resident's diagnosis list and determine the resident behaviors based on the diagnosis. She said if a resident had a diagnosis of bipolar disorder, she would monitor for mania. She said if the resident had a diagnosis of schizophrenia, she would monitor for hallucinations and delusions. She said the nurses had to determine on their own what agitation, hallucinations, anger and mania looked like for each resident.</p> <p>CNA #3 and CNA #4 were interviewed together on 6/11/25 at 1:34 p.m. CNA #3 and CNA #4 said Resident #51 and Resident #7 did not have any behaviors or history of mental illness.</p> <p>CNA #4 said Resident #17 had behaviors of not wanting to get up in the morning and being verbally aggressive towards staff when attempting to get her up. CNA #4 said the staff reapproached her later and sometimes that worked but she was not aware of any other non-pharmacological interventions to use for Resident #17.</p> <p>CNA #3 said she had worked at the facility for a year and a half but was not aware if the CNAs could customize behaviors or interventions in the CNA charting. She said she always went to the nurse to report behaviors.</p> <p>CNA #3 and CNA #4 said management would show them the resident behaviors and interventions if they were in the care plan, but the CNAs did not have access to the care plans on their own.</p> <p>Licensed practical nurse (LPN) #5 was interviewed on 6/11/25 at 1:50 p.m. LPN #5 said Resident #51 did not have any behaviors and she was unaware of what mania looked like for Resident #51.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>LPN #5 said sometimes Resident #7 had behaviors of refusing care but she would just try reapproaching him, although that did not always work.</p> <p>LPN #5 said Resident #17 had behaviors of not wanting to get up from bed and hitting the staff and the staff would try to reapproach her. LPN #5 was not aware of any medication specific target behaviors and person-centered interventions for Resident #17, Resident #51 and Resident #7. She said the nurses documented behaviors in the progress notes and the nurses had to use their own judgment on what agitation, hallucinations, anger, and mania looked like for each resident.</p> <p>The SSD was interviewed on 6/12/25 at 11:28 a.m. The SSD said the efficacy of psychoactive medications was reviewed during the facility's psychoactive pharmacological management meeting and the behavior monitoring was used to determine if dose reductions were appropriate or if a medication needed to be increased. The SSD said she reviewed the resident's behavior progress notes and the CNA charting for behaviors throughout the three-month review period. She said the nurse charting on the MARs showed up in the progress notes.</p> <p>The SSD said nurses and CNAs were trained to document behaviors, non-pharmacological interventions tried and whether the interventions were effective or not in the CNA charting and the behavior progress notes. She said she did not believe there had been formal training for the staff. She said the expectation was verbalized to the staff but she had not provided the staff with any training on how behaviors were to be documented.</p> <p>The SSD said the staff should be documenting behaviors that were disruptive to the environment or other residents but she could not say how the staff obtained this resident specific information other than through verbal notification by the SSD. She said when new behaviors were identified, the target behaviors were updated in the care plan and matched what was on the behavior monitoring physician's order. She said she did not know who specifically wrote the behavior monitoring orders.</p> <p>The SSD said every resident on psychoactive medications should have individualized behaviors and non pharmacological interventions in their care plan. The SSD was not aware the staff did not know where to find resident specific behaviors or person-centered non pharmacological interventions but said the process needed to be improved as far as ensuring behavior monitoring physician's orders and care plans were more individualized and provided better guidance to the staff.</p> <p>Primary care physician (PCP) #1 was interviewed via telephone on 6/12/25 at 2:25 p.m. PCP #1 said his understanding of the facility's process for determining the efficacy of psychoactive medications was to discuss the medications in the monthly psychoactive pharmacological management meeting. PCP #1 said the appropriate use of medications and if a dose reduction was needed were also discussed during that meeting.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The external behavioral health psychiatrist was interviewed via telephone on 6/12/25 at 2:50 p.m. The external behavioral health psychiatrist said she was one of several behavioral health providers that rotated seeing the residents at the facility. The external behavioral health psychiatrist said her expectation would be that the facility would attempt non-pharmological interventions with residents and if the interventions were not effective, try alternative interventions, and if all were ineffective, look at medication management along with the continued use of non-pharmological interventions. She said when someone from her group visited a resident, the provider checked in with the SSD before the visit, made a progress note of the visit and left it in the resident's EMR. She said the provider checked out with the SSD after the visit. The external behavioral health psychiatrist did not know Resident #17, Resident #51 or Resident #7 specifically.</p> <p>The nursing home administrator (NHA) was interviewed on 6/12/25 at approximately 4:00 p.m. She said either the nurse or the RCR entered the behavior monitoring physician's order and the information on the order was based on information obtained from the nurses and CNAs. The NHA said the staff could access the care plan for resident specific care approaches, to include medication specific target behaviors and person-centered interventions. She said the facility had a training with the staff in April 2025 on how to chart behaviors. The NHA said he was not part of the training and could not say whether or not how to find resident specific behaviors and person-centered interventions were discussed in the training.</p> <p>The NHA said if a resident was on more than one drug class medication, (an antidepressant, an antipsychotic, or mood stabilizer) each drug class should have its own behavior monitoring physician's order. She said the facility did not have resident specific behaviors or person-centered interventions on the behavior monitoring physician's order and expected the staff to look for that information in the care plan but she could not say how that expectation had been communicated to the staff.</p> <p>VI. Facility follow-up</p> <p>The CNA behavior monitoring, psychoactive medication gradual dose reductions and psychoactive medication risk/benefits for Resident #51, Resident #17 and Resident #7 were requested from the NHA on 6/11/25 at approximately 5:12 p.m.</p> <p>The CNA behavior monitoring was provided for Resident #51, Resident #17 and Resident #7 on 6/13/25 at 10:04 a.m. (after the survey exit). The CNA behavior monitoring, from 4/1/25 to 6/11/25, revealed Resident #51, Resident #17 and Resident #7 had not displayed any behaviors.</p> <p>-The psychoactive medication gradual dose reductions and psychoactive medication risk/benefits for Resident #51, Resident #17 and Resident #7 were not provided.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure services met professional standards of practice for four (#41, #111, #261 and #264) of 13 residents out of 32 sample residents.</p> <p>Specifically, the facility failed to ensure medications were not left at residents' bedsides and nurses monitored residents when they took their medications.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to [NAME] [NAME] and [NAME] [NAME], Clinical Procedures for Safer Patient Care (2015), retrieved on 6/17/25 from https://wtcs.pressbooks.pub/nursingskills/chapter/15-2-basic-concepts-of-administering-medications/#:~:text=The%20scope%20of%20practice%20regarding,in%20Open%20RN%20Nursing%20Pharmacology revealed, in pertinent part,</p> <p>Position the patient receiving oral medication in an upright position to decrease the risk of aspiration (choking). Patients should remain in this position for 30 minutes after medication administration, if possible. Remain with the patient until all medication has been swallowed before documenting to verify the medication has been administered.</p> <p>II. Facility policy and procedure</p> <p>The Medication Administration policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/11/25. It revealed in pertinent part,</p> <p>Observe that the resident swallows oral drugs. Do not leave medications with the resident.</p> <p>III. Resident #41</p> <p>A. Resident status</p> <p>Resident #41, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included peripheral vascular disease and malnutrition.</p> <p>The 3/4/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.</p> <p>The MDS assessment indicated the resident did not have swallowing problems.</p> <p>B. Observations</p> <p>On 6/1/25 at 11:30 a.m. registered nurse (RN) #2 was preparing medications for Resident #41. RN #2 dispensed two medications, metoprolol and Lyrica, into a medication cup. She walked to Resident #41's room, handed the medication cup to the resident, told him those were his medications and walked away before the resident had a chance to take his medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>IV. Resident #111</p> <p>A. Resident status</p> <p>Resident #111, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included low sodium levels and pain related to surgical site after hip surgery.</p> <p>The MDS assessment had not been conducted at the time of the survey.</p> <p>B. Observations</p> <p>On 6/11/25 at 11:48 a.m. RN #2 was preparing medications for Resident #111. RN #2 dispensed two tablets of Tylenol and one sodium chloride tablet into a medication cup. She took the medication cup to the resident's room, gave the cup to the resident and told her those were her medications. Resident #111 held the medication cup in her hand and RN #2 left the room without ensuring that the resident swallowed the medications. The resident had several family members visiting her in the room.</p> <p>RN #2 returned to the medication cart and began preparing medications for Resident #261.</p> <p>At 11:53 a.m. when RN #2 was walking to Resident #261's room to give Resident #261 her medications, a family member came out of Resident #111's room saying that Resident #111 was choking on her medications.</p> <p>Upon entering the room, Resident #111 was observed sitting on the bed with water dripping out of her mouth onto her gown and she was having difficulty swallowing the medication. Eventually, the resident was able to swallow the medications in the presence of RN #2.</p> <p>-However, RN #2 failed to observe Resident #111 taking her medications when she initially handed the medication cup to the resident at 11:48 a.m. (see observation above).</p> <p>C. Resident interview</p> <p>Resident #111 was interviewed on 6/12/25 at 1:30 p.m. Resident #111 said she recalled the incident with having difficulty swallowing her medications on 6/11/25. She said she was given three medications and one of the medications got stuck as she attempted to swallow it and she was not able to swallow it. She said the water poured out of her mouth and she felt like she was going to choke on the medication. She said she was able to eventually swallow her medications after the nurse came to the room.</p> <p>V. Resident #261</p> <p>A. Resident status</p> <p>Resident #261, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included rheumatoid arthritis.</p> <p>The MDS assessment had not been conducted at the time of the survey.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Observations</p> <p>On 6/1/25 at 12:07 p.m. RN #2 walked into Resident #261's room with the medication cup containing the resident's medications. Resident #261 was in bed with the head of her bed slightly (at approximately a 30 degree angle). She had a lunch tray in front of her and was trying to eat her lunch. RN #2 handed the resident the medication cup which contained two tylenol tablets, checked that the resident had water and walked away from the room. RN #2 did not reposition the resident to an upright position and did not stay in the room to ensure the medications were taken.</p> <p>VI. Resident #264</p> <p>A. Resident status</p> <p>Resident #264, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included cognitive communication deficit.</p> <p>The MDS assessment had not been conducted at the time of the survey.</p> <p>B. Observations</p> <p>On 6/11/25 at 12:15 p.m. RN #2 entered Resident #264's room and placed a plastic medication cup in front of the resident. The cup was filled with liquid protein solution. Resident #264 said he did not want what was in the cup. RN #2 told the resident he had to drink what was in the cup. She left the room and left the medication cup with the resident.</p> <p>VII. Staff interviews</p> <p>RN #2 was interviewed on 6/11/25 at 12:10 p.m. RN #2 said she gave Resident #111 her medications and she believed the resident put the medications in her mouth. She said she did not realize the resident did not swallow the medications.</p> <p>RN #2 said Resident #41 was alert and oriented and she felt comfortable leaving medications with him.</p> <p>RN #2 said she thought Resident #261 swallowed her medications when she was in the room.</p> <p>RN #2 said she did not know what to do when residents refused to take medications, as Resident #264 had done. She said she would usually just leave the medications in the room.</p> <p>Licensed practical nurse (LPN) #1, who was filling in for the director of nursing (DON) position, and the regional clinical resource (RCR) were interviewed together on 6/11/25 at approximately 3:00 p.m. LPN#1 and the RCR said nurses must observe residents taking the medications to ensure residents safely swallowed the medications.</p> <p>The RCR said education to all nursing staff would be initiated to ensure medications were administered to residents in a professional manner. She said RN #2 would be educated immediately and followed by a nurse manager to ensure she was adhering to professional standards of administering medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>VIII. Facility follow-up</p> <p>On 6/12/25, during the survey, the RCR provided the following information:</p> <ul style="list-style-type: none"> -Observation audits that were completed for RN #2 on 6/12/25; -Resident #111 was evaluated by the speech therapist (ST) on 6/12/25, who determined that Resident #111 had moderate cognitive impairment, reduced safety awareness and reasoning. The ST determined that Resident #111 did not have swallowing problems and was on a regular diet and thin liquids; and, -An action plan that was initiated by the facility on 6/11/25, after the above medication administrations observations. The action plan included education and continued audits. 		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the residents environment remained as free of accident hazards as possible and ensured adequate supervision was provided for one (#18) of five residents reviewed out of 32 sample residents.</p> <p>Resident #18, who was at risk for falls related to weakness, multiple sclerosis (an autoimmune disease that affects the central nervous system) and a history of falls, was admitted to the facility on [DATE] for a long-term care stay due to the progressive nature of her illness. Per the resident's care plan, she required total staff assistance for activities of daily living (ADL), including showers.</p> <p>Resident #18 experienced an unwitnessed fall on 4/16/25 when she was left unsupervised in the main shower room, resulting in a fracture of her right femur.</p> <p>Specifically, the facility failed to provide adequate supervision for Resident #18 during her shower, which resulted in Resident #18 falling and sustaining a fracture of her right distal femur, which required surgical repair.</p> <p>Findings include:</p> <p>Observations, record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/10/25 to 6/12/25, resulting in the deficiency being cited as past noncompliance with a correction date of 4/16/25.</p> <p>I. Fall incident on 4/16/25</p> <p>Resident #18 experienced an unwitnessed fall on 4/16/25 when she was left unsupervised in the main shower room, resulting in a fracture of her right femur.</p> <p>II. Facility plan of correction</p> <p>The corrective action plan the facility implemented in response to the accident on 4/16/25 involving Resident #18 was provided by the regional clinical resource (RCR) on 6/12/25 at 4:16 p.m.</p> <p>The plan included the following:</p> <p>CNA #4 was interviewed and provided education on 4/16/25 to ensure residents were not left unattended in the shower room.</p> <p>Education was provided to all nursing staff on shower safety on 4/16/25 and ensuring risk management incident reports were completed to include appropriate notification.</p> <p>Ongoing random audits were to be completed weekly to ensure residents were not left unattended in the shower.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>III. Facility policy and procedure</p> <p>The Fall Management policy, revised on 2/29/24, was provided by the RCR on 6/16/25 at 3:20 p.m. It read in pertinent part,</p> <p>The purpose of the Fall Management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury.</p> <p>A fall reduction program will be established and maintained to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs.</p> <p>The facility will educate and communicate implemented interventions to direct care staff.</p> <p>IV. Resident #18</p> <p>A. Resident status</p> <p>Resident #18, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis, bipolar disorder, depressive episodes, stiffness of the right and left knee, stiffness of the right and left ankle and fracture of the right femur.</p> <p>The 3/24/25 minimum data set (MDS) assessment revealed Resident #18 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #18 required total staff assistance with personal hygiene, toileting and showers. She was independent with mobility in an electric wheelchair; however, she required total staff assistance with all transfers.</p> <p>B. Resident interview</p> <p>Resident #18 was interviewed on 6/10/25 at 12:07 p.m. Resident #18 said she was left unattended in the main shower room by herself and when the staff member returned to the shower room, she was on the floor. The resident said she sustained an injury to her right femur, which needed surgery to repair. Resident #18 said she spent five days at the hospital after the surgery and was admitted back to the facility on 4/21/25. The resident said that due to the fall incident, she has been afraid of taking showers.</p> <p>C. Record review</p> <p>The long-term care level of care assessment, completed on 11/23/23, revealed Resident #18 required hands-on assistance or line-of-sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.</p> <p>The ADL care plan, initiated 11/18/21 and revised 11/25/24, revealed Resident #18 had ADL care deficits related to weakness and advanced multiple sclerosis. Interventions included maximum assistance from two staff members and a Hoyer lift (mechanical lift) to move between surfaces as needed and as necessary with all transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The fall care plan, initiated 11/18/21 and revised 2/24/23, identified that Resident #18 was at risk for falls. Pertinent interventions included anticipating and meeting the resident's needs.</p> <p>The facility's fall investigation for Resident #18's 4/16/25 fall was provided by the RCR on 6/11/25 at 1:41 p. m.</p> <p>Review of the 4/16/25 fall investigation revealed Resident #18 was left unsupervised and found on the floor with a shower chair tipped over her. Resident #18 was lying on the right side of her body with her arm wrapped within the shower chair, requiring staff assistance to be removed.</p> <p>The investigation documented that a registered nurse (RN) post-fall assessment revealed no signs and symptoms of injury; however, there was noted swelling of the resident's right knee. Resident #18 complained of pain and an Xray was ordered. Upon review of the Xray, Resident #18 was transported to the emergency department for further evaluation.</p> <p>The investigation included a written report from an RN The report documented that certified nurse aide (CNA) #4 assisted Resident #18 with her shower. The report documented CNA #4 reported that during Resident #18's shower, she turned away from the resident to get assistance from another staff member and upon her return, Resident #18 was found on the floor in the shower room with the shower chair tipped over the resident.</p> <p>The 4/16/25 nursing progress note documented Resident #18 fell during a shower. CNA #4 informed the nurse of the fall. Before the fall, CNA #4 reported Resident #18 was upset because CNA #4 could not understand what she needed. CNA #4 reported the resident began crying and flailing her arms. CNA #4 left the resident unsupervised to look for help, and upon returning, found Resident #18 on the floor. Xrays were ordered due to Resident #18 exhibiting noted swelling to the right knee and ice was applied. Resident #18 reported severe leg pain.</p> <p>The 4/17/25 summary of episode note assessment documented that Resident #18 had a fall which resulted in a right femur fracture with right leg pain. Resident #18 was sent to the hospital on 4/16/25, where she underwent an intramedullary nailing (IMN) (a surgical procedure used to fix a bone fracture) on 4/18/25 and returned to the facility on 4/21/25.</p> <p>V. Staff interviews</p> <p>CNA #4 was interviewed on 6/11/25 at 1:44 p.m. CNA #4 said Resident #18 required total staff assistance with showers and could not be left alone in the shower. CNA #4 said that while assisting Resident #4 with a shower on the day of the resident's fall (4/16/25), the resident became agitated because she could not understand what the resident was trying to tell her. CNA #4 said she left the shower room to look for help and found Resident #18 on the shower room floor when she returned. CNA #4 said the resident sustained a right leg injury and was sent to the emergency department. CNA #4 said she did not use the call light in the shower room to call for help because she thought she would have to wait for a long time for another staff member to respond. She said she was not familiar with Resident #18's care and did not understand what she wanted her to do.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed practical nurse (LPN) #4 was interviewed on 6/11/25 at 1:55 p.m. LPN #4 said Resident #18 should not have been left in the shower room unsupervised. LPN #4 said the resident required supervision at all times during showers. She said Resident #18 suffered a fracture to the right femur, which required a surgical procedure to repair. LPN #4 said CNA #4 should have used the call light and remained with the resident until help arrived.</p> <p>The director for rehabilitation (DOR) was interviewed on 6/11/25 at 2:48 p.m. The DOR said Resident #18 was dependent on staff assistance for ADLs, including showers. The DOR said when residents who required assistance with showers were left unsupervised in the shower room, it could result in major injuries and hospitalization. She said Resident #18 was left in the shower room alone (on 4/16/25), which resulted in a fall with injury that required a surgical procedure to fix.</p> <p>The RCR was interviewed on 6/12/25 at 2:50 p.m. The RCR said he knew about Resident #18's fall incident and the investigation on 4/16/25. The RCR said that all dependent residents should not be left alone in the shower unsupervised. He said Resident #18 fell and sustained a fracture to her right femur, which required surgery. He said CNA #4 should have utilized the call light and stayed with the resident until another staff member came to assist her.</p> <p>The RCR said the facility immediately initiated an action plan on 4/16/25 about shower safety. He said CNA #4 was interviewed and provided education to ensure residents were not left unattended in the shower room. The RCR said he did not know the reason CNA #4 left Resident #4 alone instead of using the call light.</p> <p>The nursing home administrator (NHA) was interviewed on 6/12/25 at 4:55 p.m. The NHA said she was involved in the 4/16/25 fall investigation for Resident #18. The NHA said all fall incidents were reviewed by the interdisciplinary team (IDT). She said education was provided to all nursing staff on the proper way to use the call light to call for assistance and ensuring that dependent residents were not left unattended in the shower.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review and interviews, the facility failed to ensure the facility had a designated registered nurse (RN) acting as the director of nursing (DON).</p> <p>Specifically, the facility failed to have a designated RN as the facility's fulltime DON.</p> <p>Findings include:</p> <p>I. Record review</p> <p>The facility's DON job description, created 12/28/22, was requested on 6/12/25 at 5:14 p.m. The job description was provided by the nursing home administrator (NHA) on 6/16/25 (after survey exit) at 4:59 p.m. It read in pertained part,</p> <p>Essential functions: Perform administrative duties such as: completing medical documents, reports, evaluations, studies, charting, evaluate accident/incident reports and implement interdisciplinary solutions, assure adequate supplies are available including but not limited to pharmaceuticals, resident personal supplies and equipment, prepare a plan of care for each resident that identifies the problems/needs, indicate the care to be given, goals to be accomplished and which professional service is responsible for each element of care, and coordinate with outside agencies including but not limited to; hospitals, hospice, home health, lab, x-ray, DME companies.</p> <p>Other duties: Develop, organize, implement, evaluate and direct the nursing service department, develop, organize, implement and evaluate programs and activities including but not limited to; restorative nursing, QAPI (quality assurance process improvement), prepare, plan, schedule and participate in nursing in-service meetings, determine and ensure appropriate staffing to meet the needs of the residents, provide employee reviews, employee feedback, corrective actions and determine dismissal of nursing services employees, and make rounds to assess quality of care performance and teamwork by employees, assuring quality service and safety.</p> <p>A staff list was requested on 6/10/25 at approximately 10:00 a.m. The staff list was provided on 6/17/25 (after survey exit) at 8:38 a.m. and revealed the facility did not have an acting DON.</p> <p>II. Staff interviews</p> <p>The NHA was interviewed on 6/10/25 at 9:00 a.m. upon survey entrance. The NHA said the facility did not currently have a designated RN acting as the full time DON.</p> <p>Licensed practical nurse (LPN) #1 and the regional clinical resource (RCR) were interviewed together on 6/11/25 at approximately 3:00 p.m. LPN #1 said she was sharing the DON duties with another nurse, the minimum data coordinator (MDSC), and the RCR. LPN #1 said the DON responsibilities were shared by the three of them. She said she assisted with auditing orders for admissions, follow up on fall recommendations, wounds and answering questions for the nurses on the floor. LPN #1 said she worked at least forty hours per week, plus nights and weekends when required to complete the duties.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The NHA was interviewed on 6/12/25 at approximately 4:00 p.m. She said the facility had been without a full time RN as an acting DON since 5/5/25. The NHA said the facility had made an offer to a new DON but as of today (6/12/25), that individual had not officially accepted the offer for employment. The NHA said LPN #1, the MDSC and the RCR assisted with the DON responsibilities. She said the RCR was not in the building every day but could be reached remotely or by phone. The NHA said the MDSC was an RN. The NHA said the MDSC also covered restorative therapy and MDS duties in addition to assisting with DON duties. The NHA acknowledged each of these was a stand alone full time position.</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#51 and #18) of three residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 32 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Identify Resident #51 had a history of suicide attempts and suicidal ideation in order to monitor for worsening signs and symptoms of depression or suicidal ideation; and, -Address identified psychosocial distress impacting a resident's level of functioning for Resident #18, who expressed fear of showers after a fall with major injury in the shower. <p>Findings include:</p> <p>I. Resident #51</p> <p>A. Resident status</p> <p>Resident #51, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included bipolar disorder, Parkinson's disease and dementia.</p> <p>The 3/25/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #51 was independent with her activities of daily living (ADLs) and used a walker for ambulation.</p> <p>The MDS assessment revealed Resident #51 had expressed feeling down, depressed or hopeless for several days during the assessment look back period.</p> <p>B. Record review</p> <p>The trauma informed care plan, revised 12/13/24, revealed Resident #51 had a history of trauma related to the loss of her father at a young age. Interventions, initiated 11/21/24, included assessing the resident's need for additional services and therapeutic supports or specialists from the community.</p> <p>The behavior care plan, revised 4/3/25, revealed Resident #51 took anti-psychotic medications related to the diagnosis of bipolar disorder. Target behaviors included mania/increased energy, racing thoughts, poor sleep, rapid speech, hyper focus, self-isolation, depressive statements and psychosis. Interventions, revised 8/13/24, included developing a program of activities that was meaningful and of interest to the resident.</p> <p>-The comprehensive care plan failed to identify any history of suicide attempts or expressions of suicidal ideations (see psychotherapy notes below).</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #51's June 2025 CPO revealed the following physician's orders:</p> <p>Aripiprazole (an antipsychotic medication) 10 milligrams (mg). Give one once a day for bipolar disorder, ordered 10/1/24.</p> <p>Monitor behaviors for antipsychotic use. Document number of episodes of target behavior, interventions attempted and effectiveness. Target behaviors: 1. Isolation 2. Hallucinations Interventions: a. Redirection b. One-on-one c. Activity d. Low stimulation environment e. Offer toileting f. Offer snacks g. Offer fluids h. Assess for pain i. Other-document in progress notes, ordered o 10/1/24.</p> <p>Depakote (mood stabilizer) 500 mg. Give one tablet in the morning for bipolar disorder, ordered 4/10/25.</p> <p>Depakote 250 mg. Give one tablet at bedtime for bipolar disorder, ordered 4/10/25.</p> <p>-The physician's orders failed to include behavior monitoring for attempts or expressions of suicidal ideations.</p> <p>Review of Resident #51's electronic medical record (EMR), from 2/1/25 to 6/12/25, revealed the following progress notes:</p> <p>The psychotherapy initial assessment note, dated 2/12/25, revealed Resident #51 disclosed having had suicidal thoughts in the past.</p> <p>A psychotherapy follow-up note, dated 3/11/25, revealed Resident #51 reported depression, racing thoughts and feelings of loneliness. Resident #51 had disclosed to the psychiatric nurse practitioner (NP) that she had attempted to overdose on pills in her past. Behavior intervention recommendations included monitoring, assessing and documenting depression and anxiety symptoms, rapid changes in mood, suicidal/homicidal ideations and hallucinations.</p> <p>A psychosocial gradual dose reduction (GDR) note, dated 4/1/25, revealed staff reported Resident #51 had a recent incident of becoming upset regarding her room situation, making a statement of not wanting to be here anymore and she had another incident on an outing where she became tearful and anxious.</p> <p>-However, despite the resident's expression of not wanting to be here anymore, review of the resident's EMR failed to reveal the facility was monitoring the resident for signs and symptoms of depression or suicidal ideation.</p> <p>A psychosocial social services note, dated 4/2/25, revealed Resident #51 had been presenting with instances of extreme agitation over the previous week. Additionally, Resident #51 had reported challenges with sleep. The resident's sister advised the facility poor sleep, rapid speech, hyper fixation and racing thoughts were indicators of mania for Resident #51. Resident #51 informed the social services director (SSD) that she was experiencing those symptoms. The resident's medication was to be reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A psychotherapy follow-up note, dated 4/9/25, revealed Resident #51 reported to the psychiatric NP that she had been experiencing depression over the past month with mood elevation and a worsening of tremors related to her Parkinson's diagnosis.</p> <p>A psychotherapy follow-up note, dated 4/23/25, revealed Resident #51 continued to report manic episodes with difficulty sleeping, decreased appetite and episodes of anxiety.</p> <p>A psychotherapy follow-up note, dated 5/7/25, revealed Resident #51's primary focus during the visit were on her worsening tremors, which were significantly impacting her daily functioning. She expressed frustration and tearfulness to the psychiatric NP about how ineffective she believed her medications were in treating her tremors.</p> <p>A psychotherapy note, dated 5/21/25, revealed Resident #51 had discussed feelings of low self esteem or guilt and fears of rejection, dependency and abandonment. Additionally, she continued to struggle with healthy thoughts. Therapy objectives for Resident #51 included verbalizing grief, fear and anger regarding real or imagined losses.</p> <p>A psychotherapy follow-up note, dated 5/21/25, revealed Resident #51 had expressed feelings of disappointment and discouragement related to a lack of improvement in her tremors, despite medication changes and physical therapy, which she reported had increased in difficulty for her.</p> <p>-However, despite the psychotherapy notes indicating Resident #51 was reporting discouragement, tearfulness, feelings of loneliness and abandonment and struggling with healthy thoughts, review of the resident's EMR failed to reveal documentation to indicate the facility the facility was monitoring the resident for signs and symptoms of depression or suicidal ideation.</p> <p>II. Staff interviews</p> <p>Certified nurse aide (CNA) #5 was interviewed on 6/11/25 at 1:11 p.m. CNA #5 said Resident #51 did not have any behaviors. CNA #5 said she was not aware of any signs of symptoms of depression or a history of suicidal ideations or attempts for the resident.</p> <p>Registered nurse (RN) #2 was interviewed on 6/11/25 at 1:26 p.m. RN #2 said she did not know Resident #51 very well but she said if a resident had a history of suicidal ideations or attempts, there should be a behavior monitoring physician's order with the signs and symptoms to observe for and report to social services.</p> <p>CNA #3 and CNA #4 were interviewed together on 6/11/25 at 1:34 p.m. CNA #3 and CNA #4 said that Resident #51 did not have any behaviors or history of mental illness, to include a history of suicidal ideations or attempts, however, they said the resident did isolate herself in her room for long periods of time.</p> <p>Licensed practical nurse (LPN) #5 was interviewed on 6/11/25 at 1:50 p.m. LPN #5 said Resident #51 did not have any behaviors and she was unaware of what depression symptoms looked like for Resident #51.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD was interviewed on 6/12/25 at 11:28 a.m. The SSD was not able to identify specific indicators of depressive symptoms for Resident #51. The SSD said she was not aware the resident had made statements to staff about not wanting to be here or that she had shared a history of suicidal ideations and attempts with the therapist and the psychiatrist. The SSD said she would expect those things to be reported to her but acknowledged that she did not review the behavioral health notes regularly.</p> <p>The SSD said it would be important for staff to be aware of Resident #51's types of behaviors and history in order to be prompt in reporting to the SSD or nursing home administrator (NHA) potential indicators of increasing depression or thoughts of suicidal ideation in order to prevent the resident from self-harming. The SSD said increases in episodes of racing thoughts and mania, feelings of hopelessness and frustration over loss of physical abilities or declining health could all be triggers for a person with a history of suicidal ideations and attempts.</p> <p>The external behavioral health psychiatrist was interviewed via telephone on 6/12/25 at 2:50 p.m. The external behavioral health psychiatrist said she was one of several behavioral health providers that rotated in seeing the residents at the facility. She said she could recall bringing up Resident #51's statement about not wanting to be here anymore in a May 2025 psychopharmacological management meeting at the facility, but she said she could not recall the outcome of that meeting or if there was an action taken by the facility in regards to the resident's statement.II. Resident #18</p> <p>A. Resident status</p> <p>Resident #18, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 CPO, diagnoses included multiple sclerosis, bipolar disorder, depressive episodes, stiffness of the right and left knee, stiffness of the right and left ankle and fracture of the right femur.</p> <p>The 3/24/25 MDS assessment revealed Resident #18 was cognitively intact with a BIMS score of 15 out of 15. Resident #18 required total staff assistance with personal hygiene, toileting and showers. She was independent with mobility in an electric wheelchair; however, she required total staff assistance with all transfers.</p> <p>B. Resident interview</p> <p>Resident #18 was interviewed on 6/10/25 at 12:07 p.m. Resident #18 said she had not taken a shower since she fell and broke her right femur in the shower room on 4/16/25, when a staff member left her in the shower room alone. Resident #18 said she was traumatized and still afraid of taking showers after the fall incident. The resident said she preferred showers, but she was afraid that the staff would leave her alone in the shower room again.</p> <p>Resident #18 said she had been receiving bed baths since she returned to the facility from the hospital after the fall. The resident said that if the facility staff would work with her to get her confidence back, she would return to taking showers, but that had not happened. The resident said she informed several staff members about her fears of taking showers due to the fall, and they would offer her bed baths. The resident said she had not received an evaluation on shower safety to help her overcome the fear of falling.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 5/21/25 psychiatric evaluation progress note documented Resident #18 had expressed fear of taking showers to the facility's nurse practitioner (NP). The NP documented that the reason for the resident's fear of the shower was unspecified.</p> <p>-Review of Resident #18's EMR did not reveal further follow-up related to the resident's fear of the shower or identify any recommendations for addressing the resident's fear.</p> <p>The trauma-informed care plan, revised 11/27/24, revealed Resident #18 required trauma-informed care due to having an increased risk for the development of mood or behavioral symptoms, given her history of childhood abuse. Pertinent interventions included social services to offer and arrange for additional services and therapeutic support or specialists from the community. Staff was to offer referrals periodically and as needed and a referral was in place for behavioral health services (initiated 11/27/24).</p> <p>-Further review of Resident #18's care plan and EMR did not reveal a follow-up assessment, evaluations, social services notes and/or referrals made to behavioral health services in response to the resident's expression of fear of showers after she fell on 4/16/25 and sustained a major injury requiring surgery.</p> <p>Cross reference F689 for failure to keep residents free of accidents/hazards.</p> <p>-Review of Resident #18's care plan did not reveal interventions for facility staff to implement when the resident expressed fear of taking showers.</p> <p>-There was no documentation in Resident #18's EMR to indicate that staff who knew about the resident's fear of taking showers after the fall reported the concern to management.</p> <p>D. Staff interviews</p> <p>CNA #3 was interviewed on 6/11/25 at 1:00 p.m. CNA #3 said Resident #18 preferred showers, but since the fall incident on 4/16/25, the resident would not take a shower. CNA #3 said the resident had expressed fear of showers and she reported it to the unit nurse. CNA #3 said the nurse asked her to offer the resident a bed bath.</p> <p>LPN #4 was interviewed on 6/11/25 at 1:22 p.m. LPN #4 said she received report from CNAs that Resident #18 expressed fear with showers due to the fall incident. LPN #4 said she spoke with the resident and she confirmed the report. LPN #4 said she told the resident she could have bed baths. LPN #4 said she did not inform social services of the resident's fear and did not remember documenting the resident's concern. LPN #4 said she should have informed the SSD and management about Resident #18's fear of falling in the shower and she should have documented the resident's fear in the progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD was interviewed on 6/11/25 at 2:25 p.m. The SSD said Resident #18 had a history of trauma and she expected the nursing staff to report any expression of fear to management. The SSD said she was informed about the resident's fall incident on 4/16/25, however, she said she did not know about the resident's expression of fear with showers. The SSD said she did not notice the 5/21/25 psychiatric evaluation progress note that made mention of the resident's expressed fear of showers. The SSD said she expected the staff to inform her and the management team of Resident #18's concerns in order to come up with a plan and interventions to help bring the resident back to baseline so she could have the confidence and feel safe to do the things she enjoyed doing.</p> <p>The regional clinical resource (RCR) was interviewed on 6/12/25 at 2:50 p.m. The RCR said management did not receive a report of Resident #18 expressing fear of showers after the fall incident on 4/16/25. The RCR said staff should have reported and documented the resident's concerns in the resident's progress notes. The RCR said he did not know the reason the staff did not report the resident's fear of taking a shower after her fall. The RCR said the facility would immediately offer education to all the nursing staff to ensure a breakdown of communication from staff to management did not occur again.</p> <p>Primary care physician (PCP) #1 was interviewed on 6/12/25 at 2:15 p.m. PCP #1 said he heard about Resident #18's fall incident, but he said he had not heard of the resident's expression of fear about taking showers after the fall. PCP #1 said the facility staff should have brought the resident's concern to the management team's attention, and the team should have conducted a therapy evaluation and developed interventions to assist the resident with her fear of falling in the shower.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, record review and interviews, the facility failed to ensure that the medication error rate was not five percent (%) or greater.</p> <p>Specifically, the facility had a medication error rate of 24%, which was six errors out of 25 opportunities for error.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Administration policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/11/25. It revealed in pertinent part,</p> <p>Observe that the resident swallows oral drugs. Do not leave medications with the resident.</p> <p>II. Medication error observations and interviews</p> <p>On 6/11/25 at 11:30 a.m. registered nurse (RN) #2 was preparing medications for Resident #41. RN #2 dispensed two medications, metoprolol and Lyrica, into a medication cup. She walked to Resident #41's room, handed the medication cup to the resident, told him those were his medications and walked away before the resident had a chance to take his medications.</p> <p>-RN #2 failed to ensure Resident #41 took his medications at the time they were administered.</p> <p>At 11:48 a.m. RN #2 was preparing medications for Resident #111. RN #2 dispensed two tablets of Tylenol and one sodium chloride tablet into a medication cup. She took the medication cup to the resident's room, gave the cup to the resident and told her those were her medications. Resident #111 held the medication cup in her hand and RN #2 left the room without ensuring that the resident swallowed the medications.</p> <p>-RN #2 failed to ensure Resident #41 took his medications at the time they were administered.</p> <p>At 12:07 p.m. RN #2 walked into Resident #261's room with the medication cup containing the resident's medications. Resident #261 was in bed with the head of her bed slightly (at approximately a 30 degree angle). She had a lunch tray in front of her and was trying to eat her lunch. RN #2 handed the resident the medication cup which contained two tylenol tablets, checked that the resident had water and walked away from the room. RN #2 did not reposition the resident to an upright position and did not stay in the room to ensure the medications were taken.</p> <p>-RN #2 failed to ensure Resident #41 took his medications at the time they were administered.</p> <p>At 12:15 p.m. RN #2 entered Resident #264's room and placed a plastic medication cup in front of the resident. The cup was filled with liquid protein solution. Resident #264 said he did not want what was in the cup. RN #2 told the resident he had to drink what was in the cup. She left the room and left the medication cup with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-RN #2 failed to ensure Resident #41 took his medications at the time they were administered.</p> <p>III. Staff interviews</p> <p>RN #2 was interviewed on 6/11/25 at 12:32 p.m. RN #2 said she gave Resident #111 her medications and she believed the resident put the medications in her mouth. She said she did not realize the resident did not swallow the medications.</p> <p>RN #2 said Resident #41 was alert and oriented and she felt comfortable leaving medications with him.</p> <p>RN #2 said she thought Resident #261 swallowed her medications when she was in the room.</p> <p>RN #2 said she did not know what to do when residents refused to take medications, as Resident #264 had done. She said she would usually just leave the medications in the room.</p> <p>Licensed practical nurse (LPN) #1, who was filling in for the director of nursing (DON) position, and the regional clinical resource (RCR) were interviewed together on 6/11/25 at approximately 2:00 p.m. LPN #1 and the RCR said nurses must observe residents taking the medications to ensure residents safely swallowed the medications.</p> <p>The RCR said education to all nursing staff would be initiated to ensure medications were administered to residents in a professional manner. She said RN #2 would be educated immediately and followed by a nurse manager to ensure she was adhering to professional standards of administering medications.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure all drugs and biologicals used in the facility were properly stored and labeled in two of three medication carts and one of two medication storage rooms.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure insulin pens were labeled with an open date; and, -Ensure inhalers were stored in a sanitary manner and labeled with resident names. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Storage policy, undated, was provided by the regional clinical resource (RCR) on 6/11/25 at 4:30 p.m. It read in pertinent part,</p> <p>The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature. Only persons authorized to prepare and administer medications have access to locked medications.</p> <p>Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.</p> <p>Unlocked medication carts are not left unattended. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses station or other secured location. Medications are stored separately from food and are labeled accordingly.</p> <p>II. Manufacturer's recommendations</p> <p>According to the manufacturer's instructions found on a package insert for Humalog,</p> <p>Humalog, an insulin lispro injection, should be stored in the refrigerator at a temperature between 2 degrees celsius (C) and 8 degrees C (36 degrees fahrenheit (F) and 46 degrees F).</p> <p>Unopened Humalog: Store in the refrigerator until the expiration date.</p> <p>Opened Humalog: Vials and cartridges: Store in the refrigerator or at room temperature (up to 30 degrees C or 86 degrees F) for up to 28 days. Prefilled pens: Store at room temperature (up to 30 degrees C or 86 degrees F) for up to 28 days.</p> <p>According to the manufacturer's instructions found on a package insert for Lantus:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Unused/Unopened: Refrigerate: Store unused Lantus vials and SoloStar pens in the refrigerator at temperatures between 36 degrees F and 46 degrees F (2 degrees C and 8 degrees C).</p> <p>Expiration Date: When stored in the refrigerator, unused Lantus will remain potent until the expiration date printed on the packaging. Do not freeze: Never freeze Lantus. If it freezes, discard it even if it thaws out. Room Temperature (Alternative): You can store unused Lantus at room temperature (up to 86 degrees F or 30 degrees C), but it will only last for 28 days.</p> <p>In-Use/Opened:Lantus SoloStar Pen: Once opened, keep the Lantus SoloStar pen at room temperature (up to 86 degrees F or 30 degrees C) and do not refrigerate. Lantus Vial: Opened vials can be stored either in the refrigerator or at room temperature (below 86&deg;F or 30&deg;C). Shelf Life: After the first use (opened), both Lantus SoloStar pens and vials should be discarded after 28 days, even if there is insulin left.</p> <p>Avoid: Keep Lantus away from direct heat and sunlight as this can degrade the insulin and make it less effective.</p> <p>According to the manufacturer's instructions found on a package insert for Ozempic:</p> <p>Ozempic should stay refrigerated until the first time you use it. You should keep it in the refrigerator (between 36 degrees F to 46 degrees F or 2 degrees C to 8 degrees C) when it's new and unused.</p> <p>After you've used your pen for the first time, you can either store your pen for 56 days at room temperature (between 59 degrees F to 86 degrees F or 15 degrees C to 30 degrees C) or you can still keep it in the refrigerator for 56 days. Keep the pen cap on when it is not in use.</p> <p>Unused Ozempic pens may be used until the expiration date printed on the label, if stored in the refrigerator. Do not freeze the pen or use it if it has been frozen. The Ozempic pen you are using should be disposed of (thrown away) after 56 days (whether kept in the refrigerator or at room temperature), even if it still has Ozempic left in it.</p> <p>III. Observations</p> <p>On 6/11/25 at 12:23 p.m. medication cart #1 was inspected in the presence of registered nurse (RN) #2. The following was observed:</p> <p>One Humalog insulin pen, one Lantus insulin pen and two Semgee insulin pens in the cart were not labeled with an open date.</p> <p>At 12:26 p.m. medication room [ROOM NUMBER] was inspected in the presence of RN #2. The following was observed:</p> <p>The medication room contained over-the-counter medications that were stored in cabinets. A 96-gallon black trash bin with a lid was in the middle of the room filled with trash. An additional large trash basket, without a lid, was filled with used gloves and food wraps. Next to it was a table with an uncovered suctioning machine and an upside down shower bench on top of it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Next to the non-working stained bidet filled with plastic and paper scraps was a large box with a biohazardous liner that contained six to seven filled sharps containers. One broken four-wheel walker was parked next to it.</p> <p>In the dusty sink, a deflated air mattress with an electric controller was observed. On top of it was an empty bucket and a brush.</p> <p>On top of the stained and dusty countertop was a locked box with controlled emergency medications (E-kit).</p> <p>The medication dispensing unit was observed in the corner of the room. Next to it was a small refrigerator with a sign that indicated the refrigerator was intended for vaccines only.</p> <p>-The vaccine storage refrigerator contained two boxes of insulin medication, in addition to flu vaccines.</p> <p>At 12:35 p.m. medication cart #2 was inspected in the presence of licensed practical nurse (LPN) #4. The following was observed:</p> <p>An undated ozempic pen was located in the cart.</p> <p>In addition, a small plastic basket was filled with seven inhalers, some were missing covers for mouth pieces and two were unlabeled with names.</p> <p>IV. Staff interviews</p> <p>RN #2 was interviewed on 6/11/25 at 12:32 p.m. RN #2 said she did not know why insulin pens were not labeled or why it was important to label it.</p> <p>LPN #4 was interviewed on 6/11/25 at 12:41 p.m. LPN #4 said inhalers should be stored in individual boxes with mouth covers for mouthpiece to ensure clean storage. She said she did not know who placed all the inhalers in one basket. She said she did not know why two inhalers were not labeled with resident names or who they belonged to.</p> <p>LPN #4 said she did not know how long the Ozempic pen could be used after it was removed from the refrigerator. She said the facility had a binder with expiration dates for medications but she could not locate it.</p> <p>LPN #1, who was covering for the director of nursing (DON) position and the RCR were interviewed together on 6/11/25 at approximately 3:00 p.m.</p> <p>LPN #1 said all insulin and Ozempic pens should be labeled with an open date to ensure they were not used past the expiration date. She said expiration times were different for different medications. She said inhalers should be stored in individual containers.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen and in the dry storage area.</p> <p>Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> -The kitchen was clean and sanitary; -Food was labeled and stored correctly in the walk-in refrigerator, freezer and the dry storage area; and, -Staff wore hairnets in the main kitchen. <p>Findings include:</p> <p>I. Failure to ensure the kitchen was clean and sanitary</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Regulations (3/16/24), was retrieved on 6/16/25. It revealed in pertinent part,</p> <p>Physical facilities shall be cleaned as often as necessary to keep them clean.</p> <p>Plumbing fixtures such as handwashing sinks, toilets, and urinals shall be cleaned as often as necessary to keep them clean.</p> <p>Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.</p> <p>Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered</p> <p>Clean equipment and utensils shall be stored covered or inverted. (Chapters 4, 5, and 6)</p> <p>B. Facility policy and procedure</p> <p>The Kitchen Sanitation policy, undated, was provided by the regional clinical resource (RCR) on 6/16/25 at 3:56 p.m. It read in pertinent part,</p> <p>All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.</p> <p>Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. Observations</p> <p>On 6/10/25 at 9:39 a.m. an environmental tour of the kitchen and dish room were conducted, the following was observed:</p> <ul style="list-style-type: none"> -The handwashing sink had Cheerios in it; -The handles to the handwashing sink had brown colored buildup around them; -Underneath the preparation tables, underneath the shelves holding hydration lids and dry goods and underneath the oven were food and debris; -The floor near the entrance of the kitchen, by the walk-in refrigerator and reach-in freezer had multiple cracks in the tiles and small missing pieces from the tile ; -Around the edges of the kitchen, where the wall meets the floor there was black colored buildup; -The cove base near the walk-in refrigerator was peeling from the wall; <p>The cove base along the bottom of the walk-in refrigerator was missing;</p> <ul style="list-style-type: none"> -A piece of the white tile on the wall close to the floor, near the entrance of the kitchen, was broken in half and the top half was missing; -The handles to the walk-in refrigerator and reach-in freezer were gritty and sticky; -The large mixer and meat slicer were not covered and were not in use; -The two large trash cans (one black one grey) in the food preparation area did not have lids. The black one was full and the grey one was half full; and, -Along the baseboards in the dish room and under the dishwashing machine was covered in debris. <p>On 6/11/25 at 4:22 p.m. the following was observed in the main kitchen:</p> <ul style="list-style-type: none"> -The large mixer and meat slicer were not covered and not in use; -The black trash can, that was is in the food preparation area was almost full and did not have a lid; -The yellow tile on the wall next to the walk-in refrigerator was dusty and had visible brown and black splatters of an unknown substance; -The front of the walk-in was dirty and had numerous brown spots on the side and on the door; <p>The corners of the kitchen had black debris and dust; and,</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The handles of the walk-in refrigerator and reach-in freezer had a white crusty substance on them.</p> <p>On 6/12/25 at 1:01 p.m. the following was observed in the main kitchen:</p> <p>-The large mixer and meat slicer were not covered;</p> <p>-There were two trash cans each one was half full and they did not have lids;</p> <p>There was debris underneath the food preparation tables and in the corners of the kitchen.</p> <p>D. Staff interviews</p> <p>The dietary manager (DM) was interviewed on 6/12/25 at 1:01 p.m. She said the large mixer and meat slicer should be covered and clean when they were not being used. She said the trash cans should have lids. She said she had not ordered the lids yet. She said the kitchen was deep cleaned once a month and there was a weekly cleaning schedule. She said she needed to check the cleaning schedule more often to make sure the cleaning was getting done. She said she has not told the maintenance director about the cracked tiles and the missing cove base.</p> <p>II. Failure to ensure foods were labeled and stored correctly in the walk-ins and dry storage area.</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), was retrieved on 6/16/25. It revealed in pertinent part,</p> <p>Food packaged in a food establishment shall be labeled, label information shall include: the common name of the food, or absent a common name, an adequately descriptive identity statement.</p> <p>Food shall be protected from contamination by storing the food in a clean, dry location, where it is not exposed to splash, dust, or other contamination and at least six inches above the floor.</p> <p>Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. (Chapter 3)</p> <p>B. Facility policy and procedure</p> <p>The Food Storage policy, revised November 2022, was provided by the RCR on 6/16/25 at 3:56 p.m. It read in pertinent part,</p> <p>Refrigerators/walk-ins are not overcrowded. Foods in walk-ins are stored off the floor</p> <p>Refrigerated foods are labeled, dated and monitored so they are used by their used-by date, frozen, or discarded</p> <p>C. Observations</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/10/25 at 9:39 a.m. the following was observed in the main kitchen:</p> <p>In the walk-in refrigerator:</p> <ul style="list-style-type: none"> -Four small tinfoil wrapped items were not labeled or dated; -A container full of dressing was not dated or labeled; and, -Inside the walk-in freezer there was a box of crinkle-cut zucchini and a box of mixed frozen vegetables that were sitting directly on the floor. <p>In the dry storage area there were three cans of thin cut sauerkraut with large fist sized dents on the side of the cans.</p> <p>On 6/11/25 at 4:22 p.m. the following was observed in the walk-in refrigerator:</p> <ul style="list-style-type: none"> -Three tinfoil wrapped items that were not labeled or dated; and, container that contained lidded souffle cups (individual portioned cups) that were not labeled or dated. <p>On 6/12/25 at 1:01 p.m. the following was observed in the main kitchen:</p> <p>In the walk-in refrigerator,</p> <ul style="list-style-type: none"> -Three tinfoil-wrapped items were not labeled or dated; and, -Two containers filled with a white sauce that were not labeled or dated. <p>In the dry storage the following was observed:</p> <ul style="list-style-type: none"> -Three dented cans of thin cut sauerkraut. <p>D. Staff interviews</p> <p>The DM was interviewed on 6/12/25 at 1:01 p.m. She said the tinfoil-wrapped items were sandwiches. She said the sandwiches should be labeled and dated. She said the souffle cups contained tartar sauce that was for dinner that evening. She said the containers should be labeled and should not be on the floor. She said food items should not be stored directly on the floors of the walk-in refrigerator or freezer. She said she sends dented cans back to the delivery people. She said she was not aware that the cans of sauerkraut had large dents.</p> <p>III. Failure to ensure staff wore hairnets prior to entering the kitchen</p> <p>A. Professional reference</p> <p>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; and unwrapped single- service and single-use articles.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Observations</p> <p>On 6/11/25 at 11:39 a.m. registered nurse (RN) #2 entered the kitchen area without wearing a hair net. She approached the main cooking area and grabbed a protein shake from the shelf.</p> <p>At 12:40 p.m. RN #2 entered the kitchen area without hair net at 12:40 p.m. to get another protein shake.</p> <p>On 6/11/25 at 4:22 p.m. An unidentified staff member came into the kitchen area, did not put on a hair net and did not wash her hands. She ordered an alternative meal for a resident and was touching hydration lids.</p> <p>C. Staff interviews</p> <p>The DM was interviewed on 6/12/25 at 1:01 p.m. She said any employee that entered the kitchen area should be wearing a hairnet.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on one of three units.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure the housekeeping staff followed the proper cleaning techniques for cleaning resident rooms and disinfecting high-frequency touched surfaces; and, -Ensure housekeeping staff performed appropriate hand hygiene. <p>Findings include:</p> <p>I. Professional reference</p> <p>According to Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection. (July 2021); Volume 113, Pages 104-114, retrieved on 6/21/25 from https://pubmed.ncbi.nlm.nih.gov/33744383/,</p> <p>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.</p> <p>According to the Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 6/21/25 from</p> <p>https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html</p> <p>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.</p> <p>Common high-touch surfaces include: bedrails; IV (intravenous) poles; sink handles; bedside tables; counters; edges of privacy curtains; patient monitoring equipment (keyboards, control panels); call bells; and, door knobs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the CDC's Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 6/21/25 from https://www.cdc.gov/handhygiene/providers/index.html, Cleaning your hands reduces the spread of potentially deadly germs to patients.</p> <p>Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.</p> <p>According to the CDC Hand Sanitizer Guidelines and Recommendations (3/12/24), retrieved on 6/23/25 from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html,</p> <p>Germs are everywhere. They can get onto hands and items we touch during daily activities and make us sick. Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you.</p> <p>There are important differences between washing hands with soap and water and using hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount). Cover all surfaces of hands.</p> <p>Rub your hands and fingers together until they are dry. This should take around 20 seconds. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.</p> <p>B. Facility policy and procedure</p> <p>The Cleaning and Disinfecting Resident Rooms policy, revised August 2013, was provided by the regional clinical resource (RCR) on 6/16/25 at 3:56 p.m. It read in pertinent part,</p> <p>General guidelines included: housekeeping surfaces will be cleaned regularly, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces would be disinfected on a regular basis, and when surfaces are visibly soiled, manufacturers' instructions will be followed for proper use of disinfectant. Walls, blinds, and window curtains in residents' areas will be cleaned when the surfaces are visibly soiled.</p> <p>Perform hand hygiene after removing gloves.</p> <p>The Hand Hygiene policy, revised August 2019, was provided by the RCR on 6/16/25 at 3:56 p.m. It read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>C. Observations</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continuous observation on 6/11/25, beginning at 12:00 p.m. and ending at 1:10 p.m., the following was observed:</p> <p>Housekeeper (HK) #1 brought a cleaning cart to the front entrance of room [ROOM NUMBER]. HK #1 removed a disinfectant solution from the cleaning cart labeled Spic and Span. HK #1 sprayed the faucet, the sink, the towel dispenser and the countertop that had the residents personal hygiene items on it with Spic and Span disinfectant solution. , without donning (putting on) gloves. HK #1 placed the spray bottle back into the cleaning cart, applied alcohol based hand sanitizer, and immediately applied gloves.</p> <p>She began cleaning the faucet and the countertops without removing the personal hygiene items on the counter. She grabbed a wet rag from a wet bucket containing sanitizing solution from the cleaning cart and wiped down the areas she had sprayed. HK #1 removed her gloves, applied alcohol based hand sanitizer and immediately donned gloves while her hands were visibly wet.</p> <p>-HK #1 failed to disinfect high-touch areas such as door knobs, bed remotes, the call lights, the light switches, over the bed table and the night stand.</p> <p>-HK #1 failed to remove the residents personal hygiene items from the bathroom counter before spraying the disinfectant onto the surface.</p> <p>At 12:32 p.m., HK #1 proceeded to the door entrance of room [ROOM NUMBER]. She sprayed the disinfectant onto the surfaces of the toilet, grab bars, towel stand and the faucet. She went back to the cleaning cart and placed the disinfectant onto the cart. She applied hand sanitizer and immediately put on gloves, while her hands were visibly wet.</p> <p>At 12:40 p.m., HK #1, with gloves on, removed a toilet brush from her cleaning cart. She touched the cleaning brush container with both hands and used her right hand to open the bathroom door by holding on to the door knob. She proceeded to clean the toilet. She placed the soiled toilet brush into the cart and removed her gloves. She put on clean gloves immediately after applying hand sanitizer, while her hands were visibly wet. She removed the broom from the cleaning cart and swept the room. She removed her gloves and put on clean gloves, without performing hand hygiene. She removed the mop from the mop bucket and mopped the room.</p> <p>-HK #1 failed to disinfect high-touch areas such as door knobs, bed remotes, the call lights, the light switches, over the over-the-bed table and the night stand.</p> <p>-HK #1 did not rub her hands with the hand sanitizer until they were dry before applying gloves.</p> <p>-HK #1 failed to clean the bathroom door knob after touching it with her soiled gloves hand from holding the toilet brush.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Wheatridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2920 Fenton St Wheat Ridge, CO 80214	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>HK #1 was interviewed on 6/11/25 at 1:00 p.m. HK #1 said she usually worked as a laundry attendant and occasionally worked as a housekeeper. She said she received education on housekeeping and hand hygiene when she started working at the facility and annually thereafter. HK #1 said she found it difficult to don gloves because her hands were still wet with hand sanitizer (see observations above). She said she knew to allow her hands to dry when using hand sanitizer. HK #1 said she should have gathered all residents' hygiene items off the sink countertop before spraying the disinfectant on the surface. She said high-touch areas should be cleaned daily. She said she forgot to clean them and would go back to clean them immediately.</p> <p>The maintenance director (MTD) was interviewed on 6/12/25 at 2:30 p.m. The MTD said he had only been in his current position for three months and was not aware that he was in charge of housekeeping.</p> <p>The RCR was interviewed on 6/12/25 at 2:50 p.m. He said the housekeepers were trained on proper cleaning techniques and had been provided the necessary education to perform their duties at the beginning of their employment and annually. The RCR said HK #1 should have allowed her hands to dry after applying hand sanitizer before donning gloves. He said high-touch areas should be cleaned daily. The RCR said the residents' personal hygiene items should be kept in a sanitary condition. The RCR said housekeeping staff would be provided with education immediately.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Based on observations and interviews, the facility failed to employ an infection control preventionist (ICP) who had completed specialized training in infection prevention and control which had the potential to affect all residents residing in the facility at the time of the survey.</p> <p>Specifically, the facility failed to maintain an onsite and/or at least part-time infection control preventionist to properly assess, develop, implement, monitor, and manage the infection prevention and control program.</p> <p>Findings include:</p> <p>A. Facility policy and procedure</p> <p>The Infection Preventionist policy, revised September 2022, was provided by the regional clinical resource (RCR) on 6/16/25 at 3:56 p.m. It read in pertinent part, The infection preventionist was responsible for coordinating the implementation and updating of the infection prevention and control program.</p> <p>Responsibilities included the following: The infection preventionist or designee coordinates the development and monitoring of the infection control program. The infection preventionist reports information related to compliance with the infection prevention and control program (IPCP) to the administrator and quality assurance and performance improvement committee, monitors changes in infection prevention and control guidelines and regulations to ensure the policies, practices, and protocols remain current, and aids in preventing and controlling the spread of infections.</p> <p>The infection preventionist provides education and training on evidence-based infection prevention and control practices.</p> <p>The infection preventionist is employed onsite and at least part-time.</p> <p>B. Record review</p> <p>A request was made for the ICP infection control certificate on 6/11/25. The minimum data set coordinator (MDSC) said she did not have an infection control certificate (see interview below).</p> <p>D. Staff interviews</p> <p>The MDSC was interviewed on 6/12/25 at 3:56 p.m. The MDSC said she was the manager for restorative nursing and also assisted with the duties of the infection preventionist. She said she did not oversee the IPCP. She said the RCR was filling in for the position. She said she did not have the ICP certification.</p> <p>The nursing home administrator (NHA) was interviewed on 6/12/25 at 4:44 p.m. The NHA said the facility did not have a designated person in charge of the IPCP. The NHA said the RCR was currently filling in as the infection preventionist.</p> <p>(continued on next page)</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The RCR was interviewed on 6/12/25 at 2:50 p.m. He said the facility did not have a designated person in charge of the IPCP. The RCR said the MDSC was filling in until the facility was able to fill the IPCP position. The RCR said he did not have the certification to fill in as the infection control preventionist.</p>		