STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Village - the Spearly Center	2205 W 29th Ave Denver, CO 80211

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure residents and their representatives had a right to participate in the development and implementation of their person-centered plan of care for two (#102 and #41) of four residents out of 37 sample residents. Specifically, the facility failed to invite R102's and R41's representatives to participate in the care conferences to review the resident's plan of care. Findings include: I. Facility policy and procedure The Service Plan policy, undated, was provided by the Health Information Manager (HIM) on 4/10/25 at 4:45 p.m. It read in pertinent part, Residents will have a service plan developed at move-in and with a change of condition. The purpose is to assist residents in maintaining independence, individuality, dignity and privacy through a written plan of care. The service plan is completed at move-in based upon the resident evaluation and level of care determination and initial wellness evaluation. It is expected that the resident will participate in the development and review of the service plans in all communities. The family, if the resident agrees, may also be present. Participation by the resident, family and all team members will be documented in the medical record. II. Resident #102 A. Resident status R102, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, bipolar disorder (mental illness), post traumatic stress disorder, chronic pain and history of pulmonary embolism (blockage of arteries in the lungs). The 2/22/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status score (BIMS) of zero out of 15. The resident was dependent on staff for hygiene, bathing and dressing. The resident needed assistance with eating and was independent with transfers. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident representative interview The representative for R102 was interviewed on 4/7/25 at 2:40 p.m. The representative said she was supposed to meet with the resident's care team once a month but did not have any meetings with them. She said the facility had not called to tell her how the resident was doing. She said she was unable to visit due to her recent schedule changes and the facility had not called her for the last care conference. She said she did not remember the last time the facility called her. C. Record review The 11/18/24 quarterly collaborative care review documentation was reviewed and revealed that R102's representative did not attend the care conference. The section of the review that indicated to document the names of people who attended the collaborative care review was left blank. The facility staff that were documented as present during review were clinical services. The 2/22/25 quarterly collaborative care review documentation was reviewed and revealed that R102's representative did not attend the care conference. The facility disciplines that were documented as present during the review were clinical services, social services and therapy. The names of facility staff who attended were listed. -A review of the R102's electronic medical record (EMR) revealed there was no documentation that the resident's representative or the resident was contacted to attend the care conferences on 11/18/24 and 2/22/25. III. Resident #41 A. Resident status R41, age less than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included anoxic brain damage and dementia. The 1/8/25 minimum data set (MD) assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15.The resident needed supervision with dressing, hygiene, bathing and transfers. He was independent at mealtime. B. Resident representative interview R41's representative was interviewed on 4/7/25 at 2:30 p.m. The representative said she used to be involved in the care conferences and had not attended a care conference with the facility in over a year. The representative said she previously joined the care conferences by phone but the facility had not invited her to recent care conferences. The representative said R41 did not know where he was and thought he was still in high school. C. Record review The 7/8/24 quarterly collaborative care review documentation was reviewed and revealed that R41's representative was not documented as present for the meeting. The facility staff documented as present for the meeting were a nurse and social worker. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/8/24 quarterly collaborative care review documentation was reviewed and revealed that R41's representative was not documented as present for the meeting and listed the resident's representative as his major decision maker. The facility staff documented as present were a nurse, dietary, connections and social worker. The 1/2/25 quarterly collaborative care review note documentation was reviewed and revealed that R41's representative was not documented as present for the meeting. The facility staff documented as present during review were clinical services and social services. The section of the review available to document the names of people who attended the collaborative care review was left blank. -A review of the R41's electronic medical record (EMR) revealed there was no documentation that the resident's representative was contacted to attend the care conferences on 7/8/24, 10/8/24 and 1/2/25. IV. Staff interviews The Social Services Director (SSD) was interviewed on 4/10/25 at approximately 9:00 a.m. The SSD said the care conference schedule was sent to the facility concierge and the concierge informed the resident when their care conference was scheduled. The SSD said most residents did not want to attend the care conference. The SSD said a resident representative could join join a care conference by video, in person or on the phone and were are always given those options. The SSD said the facility could also print the care conference notes and give the notes to the representative. The SSD said the previous social services assistant could have contacted the representatives to attend the care conferences and would try to find documentation of those records. -However, documentation that the resident representatives were notified of the care conferences was not provided. Assistant Director of Nursing (ADON) #1 was interviewed on 4/10/25 at approximately 9:00 a.m. ADON #1 said usually when R102's representative visited the facility a face to face informal meeting was held with her. ADON #1 said the facility provided updates to the representatives if they were unable to attend a care conference. The Director of Nursing (DON) was interviewed on 4/10/25 at 3:00 p.m. The DON said resident representatives should be invited to care conferences and the social services staff invited the representatives.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to provide written notification of room changes for one (#55) of two residents reviewed for notifications out of 37 sample residents. Specifically, the facility failed to: -Provide timely written notification of a room change and the reasoning to R55's; and, -Honor R55's room preferences. Findings include: I. Facility policy and procedure The Room/Roommate Changes policy and procedure, undated, was provided by the Nursing Home Administrator (NHA) on 4/10/25 at 5:27 p.m. It read in pertinent part, The social services representative will serve as an advocate for the resident's right to remain in their room placement unless the resident requests a room change, or the move is necessary for improved provision of medical or community life services. If a room change is deemed necessary, the Social Service Representative will obtain verbal consent from the resident and/or responsible party. This is documented in the community life progress notes or on a room change form. If the resident or responsible party refuses to authorize the proposed change, they are given notice five days before the change will occur. The resident or responsible party will be asked to sign the notification. They have the right to appeal the change within those five days. The appeal will be reviewed by the grievance committee and if further appeal is needed, the state health department. If the resident or responsible party chooses to appeal the proposed change, the room change shall not be made until the appeal has been resolved. The social service representative will complete the room change notice form and distribute to everyone on the notice. II. Resident #55 A. Resident status R55, age 81, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included bipolar-type schizoaffective disorder (mental disorder), borderline personality disorder and muscle weakness. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/9/25 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. B. Observations On 4/9/25 at 2:57 p.m. R55 and the Health Information Manager (HIM) were observed talking in the hallway near the Pinion unit nurse's station. The HIM was holding a room change notification and was explaining what the form was to R55. The HIM said the room change notification was from when R55 had moved rooms in December 2024. The HIM said the facility had forgotten about the room change notification forms and were catching up on them. The HIM said the room change notification document documented the resident wanted to move rooms. R55 said she had not wanted to move rooms and did not want to sign the document. C. Record review A progress note, dated 12/14/24 at 11:09 a.m., revealed R55 and her family members complained about the quality, size and placement of the room R55 was being moved to. A progress note, dated 12/14/24 at 11:50 a.m., revealed R55 was involved in a physical altercation with her roommate. Both residents were separated. Plans were underway to relocate one of the residents to a different room to prevent further conflicts. A room change notification form, dated 12/14/24, revealed R55 was moved to a different room on the same unit. The form documented the room change was due to safety. The form was signed by a social services staff member on 12/14/24. -However, the form did not document that the resident was provided written notification of the room change. A room change notification form, dated 3/24/25, revealed R55 was moved to a different room on a different unit. The form documented the room change was due to the resident wanting to move rooms. The form was signed by a social services staff member on 3/24/25. -However, the form did not document whether consent for the room change was obtained and the form was not signed by R55. -Review of R55's electronic medical record (EMR) did not reveal any notes pertaining to R55 requesting to move rooms or the room move itself. D. Staff interviews Nurse Manager (NM) #1 was interviewed on 4/10/25 at 3:26 p.m. NM #1 said the resident or their representative needed to agree to move rooms and sign the room change document prior to the room change occurring. NM #1 said the social services team prepared the room change document. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Assistant (SSA) was interviewed on 4/10/25 at 3:53 p.m. The SSA said the process for a room change began with talking to the resident or their guardian to see if they wanted to change rooms. The SSA said the facility staff sometimes showed the resident or their guardian the new room would look like in order to get them to agree to the room change. The SSA said the resident or their representative would sign and date the room change notification form. The SSA said information about the room change would be documented in the resident's progress notes. The SSA said they needed to obtain a signature from the resident or representative approving the room change prior to moving rooms. The SSA said the social services team members prepared the room change notification form. The SSA said the facility recently started using the paper room change notification form and were previously writing a progress note in the resident's EMR saying the resident or their guardian agreed to the room change. The SSA said the residents had to agree to sign the room change notification form prior to moving to a new room. The SSA said the room change notifications on 12/14/24 and 3/24/25 should have been signed by R55. The Director of Nursing (DON) was interviewed on 4/10/25 at 4:44 p.m. The DON said room change notifications were done by the social services department. The DON said the social service team members had the resident or their representative sign the room change document or get verbal consent over the phone prior to moving their room to indicate the resident or representative agreed to the room change. The DON said the room change on 12/14/24 was for R55's safety. The DON said when a room change was needed for safety the resident did not get to refuse the room change.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to develop a comprehensive care plan for one (#110) of three residents reviewed for care planning out of 37 sample residents to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to ensure a comprehensive care plan was developed to address R110's functional abilities and activities of daily living (ADL). Findings include: I. Facility policy and procedure The Service Plan policy and procedure, undated, was provided by the Nursing Home Administrator (NHA) on 4/10/25 at 5:27 p.m. The policy read in pertinent part, Residents will have a service plan developed at move-in to assist residents in maintaining independence, individuality, dignity, and privacy through a written plan of care. The service plan is completed at move-in based upon the resident evaluation and level of care determination and initial wellness evaluation. II. Resident #110 A. Resident status R110, age less than 65, was admitted on [DATE]. According to the April 2025 computerized physicians orders (CPO), diagnoses included quadriplegia (paralysis of all four limbs), legal blindness, encephalopathy (condition that causes dysfunction of the brain, resulting in altered mental state, memory loss, and other neurological symptoms) and chronic pain. The 3/8/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. The resident was dependent on staff for all ADLs. The assessment documented the resident was always incontinent of bowel and bladder. B. Resident representative interview R110's representative was interviewed on 4/7/25 at 4:10 p.m. The resident representative said she consistently told the nursing staff when R110 needed to have his incontinence briefs changed. The resident representative said she and another family member did most of R110's hygiene care. C. Record review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of R110's comprehensive care plan, revised 3/23/25, did not reveal a care plan focus or interventions pertaining to R110's quadriplegia or ADL abilities. A progress note, dated 12/2/24 at 3:19 p.m., revealed R110 was screened for ADL abilities. R110 was found to be totally dependent on staff for all ADLs. A progress note, dated 12/2/24 at 8:20 p.m., revealed R110 needed help with ADLs and was legally blind. Review of R110's Kardex (a staff directive tool) revealed the following directives: -Offer fluids and record intake; -Two-hour turns; -Ensure appropriate visual aides are available to support R110's participation in activities; and, -R110 was able to: (specify strengths). -The Kardex failed to identify what specific strengths the resident had or what he was able to do. -Additionally, there was no information documented on the Kardex regarding R110's ADLs, including the resident's toileting and transfer needs. III. Staff interviews Certified Nurse Aide (CNA) #2 was interviewed on 4/9/25 at 3:11 p.m. CNA #2 said the staff knew what ADLs the residents needed help with by referring to the residents' electronic medical records (EMR) and by working with the residents and getting to know them. CNA #2 said the EMR indicated whether the resident needed a hoyer lift, if they needed to have their incontinence brief checked or if they needed repositioning. CNA #2 said R110 was fully dependent on staff for assistance with ADLs. CNA #2 said R110 needed to be repositioned at least every two hours and needed to have his brief checked every 30 minutes as he was frequently incontinent of urine. CNA #2 said R110 was not able to tell the nursing staff if he needed to be changed. Licensed Practical Nurse (LPN) #3 was interviewed on 4/10/25 at 10:32 a.m. LPN #3 said the residents' ADL care plans were created by the floor nurses, the restorative and therapy team and the facility's MDS coordinator. -LPN #3 was not able to find an ADL focus documented on R110's comprehensive care plan. LPN #4 was interviewed on 4/10/25 at 11:22 a.m. LPN #4 said residents' ADL information was found in their care plan and on the resident's Kardex. LPN #4 said the ADL care plan was completed by the Director of Nursing (DON) on admission. LPN #4 said R110 was totally dependent on staff for ADLs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #4 was not able to find an ADL focus documented on R110's comprehensive care plan. Nurse Manager (NM) #1 was interviewed on 4/10/25 at 3:26 p.m. NM #1 said the ADL section of the care plan usually included ability information for residents, including their assistance levels needed for showers, support with eating, grooming, toileting and repositioning. NM #1 said R110 was totally dependent on staff but could communicate his needs verbally. The DON was interviewed on 4/10/25 at 4:44 p.m. The DON said the Assistant Director of Nursing (ADON) completed the ADL care plans. The DON said the ADL care plan typically contained interventions regarding repositioning, toileting and hygiene. The DON reviewed R110's EMR and said the resident did not have an ADL care plan. The DON said R110 was total care and was dependent on staff for ADLs. He said the ADL care plan would normally be used to let the staff know how to meet his needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure two (#46 and #98) of three residents received treatment and care in accordance with professional standards of practice out of 37 sample residents. Specifically, the facility failed to: -Ensure physician's orders to treat R46's skin condition on his hands were followed; and, -Ensure R98's skin rash was addressed in a timely manner. Findings include: I. Resident #46 A. Resident status R46, age 69, was admitted on [DATE]. According to the April 2025 computerized physicians orders (CPO), diagnoses included alcohol dependence with alcohol-induced persisting dementia, dermatitis and psoriasis. The 3/13/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident was independent for all activities of daily living (ADL). The assessment documented the resident did not have any issues with his skin. The assessment documented the resident received applications of ointments/medications to locations other than his feet. B. Resident interview and observations R46 was interviewed on 4/7/25 at 1:04 p.m. R46 said his skin was itchy and that it hurt to hold a cigarette when he smoked. R46 said the facility staff tried to use different lotions for him but they did not help his skin. R46 said the facility staff were not presently doing anything to fix his skin and he just had to live with it. R46's palms were covered with patches of thick scaly skin, irritated red skin and there were cracks in the skin between each of his fingers. R46 was itching his hands throughout the interview and had flakes of skin on his pants and his chair. C. Resident representative interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's representative was interviewed on 4/10/25 at 8:24 a.m. The resident representative said he had a care conference with the facility every three months and the facility called him with any changes in R46's condition. The resident representative said he was not aware of any skin issues R46 was having. The resident representative said the facility would call him if they changed any of R46's medications. D. Record review The ADL care plan, revised 3/13/24, revealed R46 had an ADL self-care performance deficit due to his dementia. Pertinent interventions included performing skin inspections, observing for redness, open areas, scratches, cuts and bruises and reporting any changes to the nurse. -Review of R46's comprehensive care plan, revised 4/8/25, did not reveal any focus or interventions related to R46's dermatitis or psoriasis. Review of R46's April 2025 CPO revealed the following physician's orders: Triamcinolone acetonide 0.1% cream (topical steroid) with instructions to apply to the right palm topically three times a day for psoriasis, ordered 2/17/25 and discontinued 4/8/25 (during the survey process). Clobetasol propionate 0.05% cream (topical steroid) with instructions to apply to both hands topically two times a day for dermatitis, ordered 4/8/25 (during the survey process). A progress note, dated 3/7/25 at 4:23 p.m., revealed R46 was seen by the dermatologist that day (3/7/25). The dermatologist said she had performed a biopsy on R46's right hand and instructed the resident to keep his hand dry for 24 hours. The dermatologist said she would discontinue the triamcinolone cream and R46 would need to gently wash his hands and apply vaseline to his hands for ten days. -However, the triamcinolone cream was not discontinued until 4/8/25 (during the survey). A wound note, dated 3/13/25 at 4:29 p.m., revealed R46 had improved palmar psoriasis. R46 refused treatment intermittently, citing discomfort using the cream. The resident's left palmar region was nearly resolved. Treatment included using clobetasol 0.05% ointment as directed. -However, clobetasol was not added to R46's orders until 4/8/25, and the resident continued to receive triamcinolone cream instead. A wound note, dated 3/20/25 at 3:05 p.m., repealed R46 had decreased plaques and dryness, and his left hand had almost resolved. Treatment included using clobetasol 0.05% ointment as directed. -However, clobetasol was not added to R46's orders until 4/8/25, and the resident continued to receive triamcinolone cream instead. An interdisciplinary team (IDT) note, dated 3/26/25, revealed R46 had palmar psoriasis with crusted plaques. R46 was refusing treatment as he said the prescribed cream was uncomfortable. The plaques affected both hands and the left hand had nearly resolved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IDT note, dated 4/2/25 at 1:45 p.m., revealed R46 had palmar psoriasis with mild crusted plaques and no open lesions. R46 refused treatment intermittently and stated he had discomfort using the prescribed creams. R46 was provided with encouragement to keep up with the treatments but was intermittently noncomplaint, resulting in a slow or stagnant progress. The left palmar area was nearly resolved. R46 underwent a biopsy of both palms to rule out eczema versus psoriasis and the results were pending. Treatment included clobetasol 0.05% cream and vaseline applied twice daily to both hands. -However, clobetasol was not added to R46's orders until 4/8/25, and the resident continued to receive triamcinolone instead. Dermatology notes, dated 4/4/25, revealed R46 was seen to follow up on a previous biopsy. The dermatologist ordered clobetasol propionate 0.05% topical ointment, with instructions to apply to hands twice daily for thirty days. Notes revealed the dermatologist offered to re-biopsy R46's hands as the previous biopsy was lost in the mail, but the resident declined the biopsy. There was concern for psoriasis but a biopsy would be needed to confirm the diagnosis. Clobetasol was re-prescribed as R46 had not been using the ointment. -However, the facility again failed to add the clobetasol order to R46's orders until 4/8/25, and the resident continued to receive triamcinolone cream instead. -Review of R46's electronic medical record (EMR) did not reveal any consent forms for the resident to be seen by the dermatologist or have the biopsy collected (see interviews below). E. Staff interviews Certified Nurse Aide (CNA) #3 was interviewed on 4/10/25 at 10:10 a.m. CNA #3 said R46 had issues with the skin on his hands. CNA #3 said the wound care team ordered medications for R46, along with a glove to keep his hand moisturized. CNA #3 said R46's skin looked better than it did before as he used to not be able to open his hand without the skin cracking. CNA #3 said R46 was independent and denied lotion whenever it was offered to him because he did not like lotion. CNA #3 said she reported any skin issues to the nurse or the unit manager, who would then alert the wound care team and assess the resident to see if the resident needed any treatment orders. Licensed Practical Nurse (LPN) #3 was interviewed on 4/10/25 at 10:32 a.m. LPN #3 said R46 had psoriasis on his palms and was being followed by wound care. LPN #3 said if a resident received new physician's orders during ancillary appointments, she would call the doctor to verify the order and put it in the EMR before calling the pharmacy to see when the medication would arrive. LPN #3 said R46 had triamcinolone cream ordered twice a day to help his skin and she had just finished administering it to R46. LPN #3 verified R46 was had triamcinolone cream ordered for his hands, and produced a box of triamcinolone cream from her medication cart with R46's name on it and said that was the medication she had administered that morning (4/10/25). -However, the order for triamcinolone cream had been discontinued on 4/8/25, and R46 had a physician's order for clobetasol ointment, initiated 4/8/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #4 was interviewed on 4/10/25 at 11:22 a.m. LPN #4 said R46 had clobetasol cream in his April 2025 CPO but he did not have triamcinolone cream ordered. LPN #4 said when a resident's medication was discontinued, the remaining medication should be removed from the medication cart and placed in the medication storage room to be picked up by the pharmacy for disposal. LPN #4 said R46 should only be receiving the clobetasol cream that was presently ordered. Nurse Manager (NM) #2 was interviewed on 4/10/25 at 2:45 p.m. NM #2 said residents were sent with a packet each time they received ancillary services for the physicians to fill out regarding what was done and any new orders prescribed for the resident. NM #2 said the packets were often sent back blank, so the facility staff would call the ancillary service physician, request any new orders and add them to the resident's EMR. NM #2 said there were times when there were delays in adding physician's orders if she was not in the facility or there was a new floor nurse. NM #2 said R46 began complaining about issues with his palms starting in February 2025, at which time his hands looked like they had a raised rash. NM #2 said the wound care team at the facility prescribed R46 the triamcinolone cream and did a biopsy on his hands, but the biopsy was lost in the mail. NM #2 said R46 was noncompliant with putting the prescribed creams on his hands as he did not like the creams. NM #2 reviewed R46's chart and said the clobetasol cream was ordered as of 3/13/25. NM #2 said there was a progress note, dated 3/7/25, in the resident's EMR which indicated the triamcinolone cream was discontinued on 3/7/25 (see record review above). NM #2 said she was out of the facility during the period of time in which the new physician's orders were received so that may have affected the facility's processes and the physician's order may have been missed in her absence. NM #2 said clobetasol was ordered for R46 and had been filled by the pharmacy, so R46 should have been receiving that medication as ordered. NM #2 reviewed R46's MAR and said the clobetasol cream had been marked as administered that morning. -However, LPN #3 administered triaminolone cream to R46 on the morning of 4/10/25 (see LPN #3 interview above). NM #2 said R46's representative needed to sign a consent form in order for the resident to be seen by the dermatologist and to have the biopsy performed. NM #2 reviewed R46's EMR and could not find any dermatology or biopsy consent forms in his record (see record review above). The Director of Nursing (DON) was interviewed on 4/10/25 at 4:08 p.m. The DON said there was no reason which should have caused the delay in the switch from triamcinolone cream to clobetasol cream for R46. The DON was interviewed a second time on 4/10/25 at 4:44 p.m. The DON said the facility's medical records staff member started in January 2025 and had a backlog of medical records to input. The DON said the facility had an issue with ancillary physicians writing orders for residents and the facility not receiving them. The DON said the facility did not have a good process for transferring orders when the dermatologist came in and prescribed new orders for residents. II. Resident #98 A. Resident status (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R98, age 69, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included bipolar-type schizoaffective disorder and major depressive disorder. The 3/15/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent for all ADLs. The assessment documented the resident did not have any issues with her skin. B. Resident representative interview R98's representative was interviewed on 4/10/25 at 8:15 a.m. The resident's representative said she learned at the resident's most recent care conference that the resident had rashes on her upper thighs. The resident's representative said the facility thought her rashes were caused by her underwear being too tight due to R98's recent weight gain. The resident's representative said R98 did not have any rashes anywhere else on her body except on her thighs. -However, the resident had additional rashes on her abdomen, chest and buttocks/groin area (see resident interview and record review below). C. Resident interview R98 was interviewed on 4/10/25 at 11:17 a.m. R98 said she was not sure if there was an issue with the soap she was using, but she had been getting red spots on her chest and stomach due to her itching. R98 said she had some dry spots on her legs as well, but the itch cream that the nursing staff gave her helped with those. D. Record review Review of R98's April 2025 CPO revealed the following physician's orders: Lantiseptic skin protectant with instructions to apply to the buttock and groin area to relieve skin rash every shift and after shower, ordered 3/27/25 and discontinued 4/10/25 (during the survey process). Lantiseptic skin protectant with instructions to apply to the abdomen, chest, buttock and groin area to relieve skin rash every shift and after shower, ordered 4/10/25 (during the survey process). Refer to dermatology for skin rash to abdomen, chest, and buttocks/groin area, ordered 4/10/25 (during the survey process). A skin evaluation, dated 3/8/25 at 10:01 a.m., revealed R98's skin was clean, dry and intact. A skin evaluation, dated 3/17/25 at 8:53 a.m., revealed R98 had a generalized rash to her abdomen and her left and right buttocks. R98 had a rash noted to her upper and lower left abdomen and to both glutes (buttocks). -However, the skin evaluation did not reveal whether the physician was informed of the resident's rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 3/18/25 at 4:50 p.m., revealed R98 had red spots all over her body and redness between her buttocks. Interventions included performing a skin check to determine the severity of the rash, removing any wet or damp clothing and reviewing recent foods, drinks, and environmental changes for a possible cause. -However, the progress note did not reveal whether the physician was informed of the resident's rash. A skin evaluation, dated 3/25/25 at 9:44 a.m., revealed R98 had a generalized rash to her abdomen, her chest, and her left and right buttocks. Notes revealed R98 had a rash present under both breasts and under each arm. R98 said the rashes itched. A skin check was performed, and the physician and the Assistant Director of Nursing (ADON) were notified. -However, the physician was not notified of R98's rash until 3/25/25, eight days after staff initially noted the rash (see progress notes above). -Additionally, there was no physician's order entered into the resident's EMR for a treatment for the rash until 3/27/25 and the initial physician's order did not include treatment to the resident's abdomen and chest (see physician's orders above). A skin evaluation, dated 4/3/25 at 5:03 a.m., revealed R98 had a generalized rash to her abdomen, her chest, and her left and right buttocks. A progress note, dated 4/10/25 at 5:19 p.m., revealed R98 was receiving Lantiseptic skin protectant to her buttock area for her skin rash. R98's rash appeared to be improving in size, and the resident was encouraged to dry her skin after her shower and apply the cream. R98's skin was otherwise intact and had no signs or symptoms of infection. A progress note, dated 4/10/25 at 5:27 p.m., revealed R98's representative consented to a referral to the dermatologist for the resident's skin rash. -However, the referral for the resident to see a dermatologist for her rash was not obtained until 4/10/25, during the survey, which was over three weeks after the rash was initially noted and spread to other areas on the resident's body. E. Staff interviews CNA #4 was interviewed on 4/10/25 at 9:16 a.m. CNA #4 said R98 had a rash all over her body the week or two prior. CNA #4 said she notified the nurse right away if she noticed an issue with a resident's skin. LPN #4 was interviewed on 4/10/25 at 10:22 a.m. LPN #4 said R98 had a rash on her buttocks and had a cream prescribed to treat the rash. LPN #4 said whenever she was notified about a skin issue on a resident, she assessed the resident then called their doctor. LPN #4 said the doctor would then give an order based on whatever type of rash the resident had and she would apply the medication as prescribed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NM #1 was interviewed on 4/10/25 at 3:26 p.m. NM #1 said R98 previously had an issue with her skin, so the nursing staff called her physician and received a physician's order for an over-the-counter cream. NM #1 said the cream prescribed to R98 was just to be used after her showers to help with itching, as the resident was generally itchy due to the dryness of her skin. NM #1 was interviewed a second time on 4/10/25 at 4:00 p.m. NM #1 said R98 only had a skin rash on her buttocks. NM #1 said R98 did not have any rashes anywhere else on her body, and that they were only administering the prescribed cream on her buttocks. -However, R98 had rashes covering several areas of her body (see record review and resident interview above). The DON was interviewed on 4/10/25 at 4:44 p.m. The DON said he had spoken with NM #1 to see if the nursing staff had contacted R98's physician about the rash on her chest. The DON said NM #1 told him the nursing staff were administering the prescribed cream to R98's abdominal folds, glutes, and groin region. The DON said he would ask NM #1 to change R98's Lantiseptic order to include administering the cream to her chest. The DON said the facility planned to refer R98 to the dermatologist if her rash was not healed by 4/15/25.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to treat and prevent pressure injuries for one (#45) of three residents reviewed for pressure ulcers out of 37 sample residents. Specifically, the facility failed to: -Provide timely assessment by a qualified person; -Provide timely interventions and treatment after new wounds were found; -Notify key individuals (hospice, wound specialist, primary physician) to ensure timely interventions, assessments, and updated care plans, were in place to avoid wounds from worsening; and, -Ensure wound care documentation was thorough and accurate. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 4/16/25 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Ulcer policy and procedure, undated, was provided by the health information manager (HIM) on 4/10/25 at 4:39 p.m. It documented in pertinent part, Residents are assessed for skin integrity and wounds upon move-in with documentation in the move-in assessment in the electronic medical record (EMR). Residents with a wound or skin integrity issue at move-in will have weekly skin assessments using the skin integrity evaluation in the EMR until the wound is healed. Residents without wounds or skin integrity issues or recently healed wounds will continue having weekly skin evaluations using the skin integrity evaluation weekly in the EMR. Follow the provider orders for specific wound treatments. Following the identification of wounds, the care plan will be updated to reflect. III. Resident #45 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #45, age 74, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included major depressive disorder, dementia, overactive bladder, hemiplegia (paralysis to one side of the body) and hemiparesis (one-sided muscle weakness) following a cerebral infarction (stroke). The 2/19/25 minimum data set (MDS) assessment documented the resident had a short term memory problem based on the staff assessment for mental status. A brief interview for mental status was not conducted due to the resident being rarely/never understood. The assessment documented the resident was dependent on staff for eating, hygiene, bathing, dressing, rolling side to side and transferring. The assessment documented the resident was always incontinent of bowel and bladder. The assessment indicated the resident was at risk for pressure ulcers and did not have any skin conditions at the time of the assessment. The resident had a pressure reducing device for the chair and the bed, turning and repositioning, nutrition or hydration interventions and application of an ointment/medication to somewhere other than to the feet. The assessment indicated the resident did not have rejections of care. B. Resident observations On 4/9/25 at 11:30 a.m. Resident #45's wound care was observed with nurse manager (NM) #2, registered nurse (RN) #1 and certified nurse aide (CNA) #5. The resident's left heel had a dark purple/maroon deep tissue injury (DTI) that RN #1 applied skin prep to. Both heels were in soft booties. Resident #45 had a large crater-like wound that was dark brown/black in color at the middle or center of the wound on his sacrum. The skin around the wound was white and red in color. The old dressing NM #2 took off was brown in color with a moderate amount of drainage from the wound. When NM #2 removed the soiled dressing, RN #1 put her shirt up to her nose to mask the scent of the wound. NM #2 said the smell of the wound was from the purulent drainage that was brown in color. She said it was a stage 3 wound. NM #2 cleansed the wound with saline, applied calcium alginate soaked in Dakin ' s solution to the wound bed, applied skin prep around the wound bed and applied a foam dressing to the wound. C. Record review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pressure ulcer plan of care, initiated 3/29/19 and revised 4/8/25 (during the survey), documented that Resident #45 had potential for pressure ulcer development because of his episodes of incontinence, poor nutritional intake and refusals for repositioning. The care plan documented he had an actual wound on his coccyx and a DTI to his left heel. The care plan goal was for Resident #45 to have no significant alteration in skin integrity through the next review period. Interventions included administering supplements as ordered though he often refused supplements (initiated 4/8/25, during the survey), an air mattress (initiated on 4/8/25, during the survey), a Broda chair (initiated 4/8/25, during the survey), coordination with hospice (initiated 4/8/25, during the survey), pain management (initiated 4/8/25, during the survey), wound round checks with the wound care team (initiated 4/2/25), skin prep to heels and heel protectors on while in bed (initiated 4/8/25, during the survey), staff to reposition resident every two to three hours, though he often refused (revised on 4/8/25, during the survey), urinal will be made available at bedside (initiated 3/29/19) and a weekly skin assessment and to notify the physician of any refusals (initiated 3/29/19). -The facility failed to update the skin integrity care plan with interventions related to the actual pressure injuries until 4/8/25, 18 days after the development of the coccyx pressure ulcer and 20 days after the development of the left heel unstageable DTI. -The facility failed to implement timely interventions to prevent Resident #45's facility acquired stage 2 pressure ulcer from progressing to a stage 3 pressure ulcer. A Braden Scale assessment (a tool used for predicting pressure ulcer risk), dated 3/11/25, documented Resident #45 was at risk for developing a pressure injury. The risk factors included not always being able to communicate discomfort, occasionally being moist, his ability to walk was severely limited or non-existent, he had very limited mobility, adequate nutrition and a potential problem for friction and shear (skin slides around). A review of the wound care provider ' s (WCP) note, dated 3/20/25, revealed Resident #45 had an unstageable DTI to the left heel from pressure. It measured 1.2 centimeters (cm) by 1.5 cm. The skin was intact with purple/deep maroon discoloration. Recommendations from the WCP included skin prep to the wound once daily, off-loading the wound and floating the resident ' s heels while in bed. -However, there were no wound care orders for the resident ' s left heel DTI until 4/10/25 (during the survey) after the discrepancy was brought to the attention of the facility (see physician ' s orders below). A review of the nursing progress note, dated 3/22/25 and written by RN #1, documented a new facility-acquired stage 2 pressure ulcer to Resident #45 ' s coccyx with partial thickness skin loss with exposed dermis. It documented that barrier cream was applied and to refer to the wound care team. -However, there was no documentation that the WCP was notified. There was no follow up from the wound care team until 3/27/25, five days later, when the WCP was at the facility and after the resident ' s wound had advanced to a stage 3 pressure ulcer. A review of the WCP note dated 3/27/25, revealed Resident #45 had a stage 3 pressure wound to his coccyx with poor healing potential. The wound measured 2 cm by 2 cm, had moderate to sero-sanguinous exudate and 100% granulation tissue. The treatment was a foam dressing with border three times weekly with skin prep to the peri wound, off load and reposition per facility protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA documentation for repositioning every two hours revealed Resident #45 refused only one offer to reposition in the 31 days in March 2025. -However, there were 17 days out of the 31 days in March 2025 where it was documented that the resident was repositioned on his back several hours consecutively. A review of Resident #45 ' s April 2025 CPO revealed the following physician's orders for wound care: Clean area of coccyx with wound cleanser, pat dry, apply Medi-honey to open area, skin prep around the wound bed and cover with bordered foam dressing, ordered 3/31/25. -The wound care was ordered 11 days after the development of the pressure ulcer to the coccyx (see progress notes above). Air mattress ordered related to skin integrity/wounds, settings on automatic firm, ordered 4/8/25. -The intervention was ordered 18 days after the development of the pressure ulcer to the coccyx (see progress notes above). Heel protectors on while in bed, ordered 3/17/25. -However, according to NM #1, the facility did not start using booties on the resident until after the development of the unstageable DTI to the left heel (see NM #1 interview below). Clean area with wound cleanser, pat dry, apply skin prep to DTI on inner right heel every shift, ordered on 3/17/25. -However, the DTI was on the resident ' s left heel. -The April 2025 CPO failed to reveal wound care orders for the resident ' s left heel unstageable DTI. E. Staff interviews CNA #8 was interviewed on 4/9/25 at 10:48 a.m. CNA #8 said Resident #45 would refuse to eat sometimes if he did not like the food. She said the staff tried to offer him alternatives if he did not like the food. She said he was incontinent and needed total assistance for all cares, including eating, repositioning and toileting hygiene. She said he did not refuse to be repositioned or to get his brief changed. NM #2 was interviewed on 4/9/25 at 11:30 a.m. NM #2 said when there was a new skin condition, the nurse who noticed it put a wellness alert in the EMR. She said this alerted the unit manager to get a referral for the WCP to see the resident. She said Resident #45 was at risk for developing pressure ulcers prior to the development of the injuries due to his poor nutrition, refusing repositioning, refusing floating his heels and refusing the booties until recently. She said Resident #45 was dependent on staff for repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, review of the CNAs repositioning documentation for Resident #45 revealed he refused only one repositioning attempt in March 2025 (see record review above). CNA #3 was interviewed on 4/10/25 at 9:07 a.m. CNA #3 said Resident #45 did not refuse care. She said the only thing he would refuse at times was eating meals and supplements. She said he got up occasionally out of bed for meals and showers. She said he was incontinent and did not use the call light. CNA #3 said the CNAs went in and repositioned him and checked his brief every two hours. RN #1 was interviewed on 4/10/25 at 9:30 a.m. RN #1 said she was the nurse for Resident #45 on a 3/22/25 when she noticed his coccyx wound worsened. She said she reached out to the resident ' s hospice team to request a visit since the nursing managers were not at the facility on weekends. -However, there was no documentation to indicate that RN #1 reached out to hospice or obtained any new physician's orders for wound care. The WCP was interviewed on 4/10/25 at 10:30 a.m. The WCP said the stage 3 coccyx wound and the left heel DTI wound on Resident #45 were caused by pressure. She said initially she was concerned the coccyx pressure wound was a Kennedy ulcer (end of life wound), but ruled that out. She said he was at risk for developing pressure ulcers due to poor nutritional status, dementia, limited mobility, being bed-bound and refusing nutritional supplements. The director of nursing (DON) and assistant director of nursing (ADON) #1 were interviewed together on 4/10/25 at 11:30 a.m. The DON said when there was a new skin condition discovered, the nurse would write a progress note, the unit manager would review it and put in a referral to the wound care nurse (WCN) and the WCN would reach out to the WCP. The DON said every resident with a new skin condition got a referral to the WCP. He said the primary care physician (PCP) very rarely managed any resident wounds. ADON #1 said she was the wound care nurse at the facility ADON #1 said Resident #45 developed the left heel DTI due to rubbing his feet against the mattress. She said once this was discovered, he started to use soft booties on his heels. She said he was not using the booties prior to the development of the left heel wound. She said he developed his coccyx wound when she was not working so another nurse should have gotten the referral to get the WCP involved. She said she was not aware of the resident ' s coccyx wound until 3/27/25. -However, there was no documentation that another nurse assessed the resident ' s coccyx wound, notified the physician on 3/22/25 or obtained wound care orders (see record review above).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#77) of five residents reviewed for accident hazards out of 37 sample residents. R77 had severe cognitive impairments. On 3/19/25, the resident took a piece of bread from another resident's plate and ate it. R77 choked and required the Heimlich maneuver (abdominal thrusts used to clear food from a person's airway that is choking) to clear the food from his airway. The resident's care plan directed staff to assist R77 with controlling his rate of eating, monitoring the resident's bite sizes to ensure the resident did not choke and monitoring the resident to avoid the resident stuffing food into his mouth. Additionally, R77 was prescribed a mechanically altered diet. Observations during the survey revealed R77 received menu items that were not consistent with his prescribed diet order. The staff failed to provide supervision during meals to ensure the resident did not take food from other residents' plates or monitor the resident's bite sizes which put the resident at a continued risk of further choking incidents for R77. The failure to provide appropriate supervision during times of resident intake placed residents at risk for serious harm or death if not corrected immediately. On 4/25/25 at 10:11 a.m., immediate jeopardy was identified based on the facility failures above that created a situation of potential serious harm for R77, requiring immediate corrective action. Findings include: I. Immediate Jeopardy A. Situation of immediate jeopardy The facility failed to ensure staff provided appropriate supervision and implemented the identified care-planned interventions for R77 after the resident had a choking incident on 3/19/25. The facility's failure to ensure staff provided appropriate supervision and implemented care-planned interventions led to a continued risk of further choking incidents for R77. B. Imposition of immediate jeopardy On 4/25/25 at 10:11 a.m., the Nursing Home Administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure R77 received appropriate supervision during times of intake. C. Facility plan to remove immediate jeopardy (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/25/25 at 4:37 p.m. the facility submitted a plan to remove the Immediate Jeopardy. The removal plan read: 1. Corrective action R77 will be served food per the physician's ordered diet of a mechanical soft diet. The Certified Nurse Aide (CNA) and/or nurse will provide R77 with supervision during times of intake to ensure he is eating safely. R77 will be placed on safety checks due to his behavior of taking other residents' food that is not within his prescribed diet texture. Any additional safety concerns or behaviors will be addressed, documented in the behavior log and will be updated on the care plan with appropriate interventions. The care plan and interventions will be reviewed and updated every quarter and with every change of condition. 2. Identification of others An audit was completed on 4/10/25 and determined 14 residents required assistance with intake. Each resident identified will be seated at a designated table in the dining room. The Restorative CNA or designee will provide active monitoring of those residents during each meal. 3. Systemic changes On 4/11/25 the facility's Diet Orders and Food Services policies were reviewed by leadership to ensure alignment with current best practices and regulatory standards. The DON (Director of Nursing)/designee provided education, starting on 4/11/25 and completed on 4/16/25, to the nursing staff of the requirement for supervision for the at-risk residents that were identified. CNAs and nurses will observe and supervise the at-risk residents identified for choking, appropriate meal texture and process of notification if an incident or concern arises. The Dietary Manager (DM) provided education, starting on 4/10/25 and completed on 4/11/25, to the cooks and servers on diet extensions to ensure proper diet textures, diet types, food procurement and scoop sizes. The kitchen will follow diet extensions at each meal. The cook appropriately prepares the meals following the diet extensions. The server sets up steam tables with all meals prepared by the cook and verifies that menus and extensions are correct. The server will plate the food based on the diet type report that is located on the steam table. The diet type report is updated as needed and with any new orders. The CNA will verify that the meal served matches the diet type report. One CNA and a nurse will be designated to each dining area for the entire meal service. One leadership member is assigned to meals to round and assist as needed. If a resident on eating supervision is given a snack, a CNA or designee must supervise the resident while they consume the snack. 4. Monitoring (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DM/designee will audit the lunch meal on 4/25/25 to ensure extensions are served correctly. Additionally, three meals will be audited daily for one week, then one meal daily for three weeks, then five random meals per week until substantial compliance. The audits will be documented on a written log and concerns will be addressed immediately. The DON/designee will audit resident supervision on 4/25/25. Additionally, three meals will be audited daily for one week, then one meal daily for three weeks, then five random meals per week until substantial compliance. The audits will be documented on a written log and concerns will be addressed immediately. D. Removal of the immediate jeopardy The NHA was notified the immediate jeopardy was removed on 4/25/25 at 5:17 p.m. based on the facility's removal plan (see above). However, the deficient practice remained at a D level, no actual harm with potential for more than minimal harm that is not immediate jeopardy. II. Facility policy and procedure The Food Service policy and procedure, undated, was provided by the NHA on 4/25/25 at 3:30 p.m. It read in pertinent part, Special diets as prescribed by a physician are available. Mealtime assistance is available as needed, based on the resident service plan. III. Failure to ensure staff provided appropriate supervision and implemented care-planned interventions A. Resident #77 status R77, age 68, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included severe dementia with agitation and delusional disorders. The 2/10/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired and could never or rarely make decisions regarding tasks of daily life. The resident required partial to moderate staff assistance for eating and was dependent on staff for all other activities of daily living (ADL). The assessment documented the resident was receiving a mechanically altered diet. B. Observations During a continuous observation of the lunch service on 4/8/25, beginning at 12:11 p.m. and ending at 12:42 p.m., the following was observed: At 12:11 p.m. R77 was sitting at a dining table with several other residents. An unidentified staff member delivered R77's meal to him and the resident began eating independently. Staff did not provide the resident with supervision to ensure he was eating safely. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 12:14 p.m. R77 speared multiple whole baby carrots and sweet potato pieces on his fork and ate them in one bite. No staff member intervened and staff did not provide the resident with supervision to ensure he was eating safely. At 12:19 p.m. multiple staff members were delivering trays of food to residents throughout the dining room and in their rooms. Staff did not provide R77 with supervision to ensure he was eating safely. At 12:22 p.m. an unidentified staff member delivered a second helping of food to R77 and promptly returned to serving trays. The unidentified staff member did not provide the resident with supervision to ensure he was eating safely. At 12:28 p.m. R77 continued eating by himself. Staff did not provide the resident with supervision to ensure he was eating safely. At 12:36 p.m. R77 finished his second helping of food and remained at the dining table with other residents. At 12:42 p.m. an unidentified staff member cleared the plates from the dining table at which R77 was sitting. Staff did not provide the resident with supervision to ensure he did not take food from another resident's plate. During a continuous observation of the lunch service on 4/9/25, beginning at 12:10 p.m. and ending at 12:50 p.m., the following was observed: At 12:24 p.m. R77 was served a slice of pumpkin pie and ate it independently. Staff did not provide the resident with supervision to ensure he was eating safely. At 12:26 p.m. R77 self-propelled to another table in the dining room. R77 grabbed food off of another resident's plate and used that resident's spoon to eat her pumpkin pie. A resident from R77's usual table in the dining room saw what was occurring and yelled out to get the staff's attention. CNA #6 assisted R77 back to his original table and gave him the other resident's remaining pumpkin pie. CNA #6 did not provide the resident with supervision to ensure he was eating safely. At 12:31 p.m. R77 began self-propelling away from the dining room. CNA #6 tried to redirect R77 back to his table and said his food was there. CNA #6 assisted R77 back to his table in the dining room where he was served lunch and began eating. CNA #6 again did not provide the resident with supervision to ensure he was eating safely. At 12:33 p.m. Restorative Nurse Aide (RNA) #1 brought R77 a glass of juice and sat down next to the resident and began providing the resident with supervision and cues for eating more slowly. C. Record review The restorative care plan, initiated 2/26/24, revealed R77 required restorative nursing for dining. Pertinent interventions included assisting R77 with controlling his rate of eating, monitoring bite size to ensure the resident did not choke and monitoring self-feeding to avoid the resident stuffing food into his mouth. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADL care plan, revised 1/30/24, revealed R77 had a self-care performance deficit due to his dementia. Pertinent interventions included R77 required staff assistance with eating. -Review of the resident's care plan did not reveal the facility identified the resident often took food from other resident's plates. Review of R77's April 2025 CPO revealed a physician's order for a regular diet with a mechanical soft texture, ordered 8/11/24. A progress note, dated 3/7/25 at 4:46 p.m., revealed R77 was observed in the dining room with a plastic soda bottle cap in his mouth. Staff were instructed to remove soda bottles from the dining tables and residents were reminded to throw their trash into the waste receptacles once they were finished with them. A progress note, dated 3/19/25 at 7:26 a.m., revealed R77 had an episode of choking during the previous meal. R77 appeared to be unable to swallow, speak, or cough. Nursing staff assisted R77 with an abdominal thrust and visible food was removed from his mouth. A Registered Nurse (RN) performed an assessment which indicated R77 was able to speak, eat and swallow. No injuries were noted at the time, vital signs were stable. Staff were to continue to observe the resident during meal times and cut his food into smaller pieces. R77's representative and physician were notified. An interdisciplinary team (IDT) note, dated 3/26/25 at 11:34 a.m., revealed R77 choked on an item that was not part of his diet texture. R77 had grabbed food from another resident's plate. R77 was monitored to ensure he was not taking food from other residents' plates. R77 sat at the restorative table while eating. The IDT team suggested the residents in the work therapy program be assigned to pick up plates when other residents were done eating. D. Menu extensions Review of the menu extensions from 4/7/25 through 4/13/25 revealed the following: The mechanical soft texture lunch meal for 4/9/25 included blackened fish, sweet potato wedges, green beans, and a pureed dinner roll. -However, R77 was served a vegetable blend instead of the green beans on the menu extensions (see observations above). IV. Staff interviews CNA #4 was interviewed on 4/10/25 at 9:16 a.m. CNA #4 said R77 spent most of his day wandering around the facility. CNA #4 said R77 sometimes tried to grab items from other residents. CNA #4 said R77 was redirectable when he tried to take other residents' items. CNA #4 said the staff had to monitor R77 during meals because he tried to take other residents' meals and drinks. CNA #4 said other residents would yell when R77 took food or drinks from other residents and would redirect him. Licensed Practical Nurse (LPN) #4 was interviewed on 4/10/25 at 9:53 a.m. LPN #4 said R77 liked to grab items and put them in his mouth so the nursing staff had to keep an eye on him. LPN #4 said she was not aware of any choking incidents R77 had. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Manager (NM) #1 was interviewed on 4/10/25 at 3:26 p.m. NM #1 said the nursing staff had to redirect R77 from going into other residents' rooms and grabbing items in the dining room. NM #1 said the nursing staff needed to monitor R77, especially during mealtimes. NM #1 said the nursing staff were good at monitoring R77 and ensuring he did not put anything inappropriate in his mouth. NM #1 said he could not recall if R77 had experienced any choking incidents. The Director of Nursing (DON) was interviewed on 4/10/25 at 4:44 p.m. The DON said R77 had a tendency to grab food from other residents' plates. The DON said R77 had previously grabbed bread from another resident's plate and choked on it. The DON said if the nursing staff saw R77 grabbing food from another resident's plate they redirected him, which in turn made R77 try to eat or get rid of whatever he had grabbed faster than before. The DON said the facility had the resident work therapy program to help clean up the dining room so there were no trays sitting out and thus limiting the amount of food R77 could potentially grab. The DON said the nursing staff increased their monitoring of R77 during meals, and that the resident sat at the restorative dining table so the RNAs could supervise him during meals. The DON said the facility was also utilizing a feeding training program for non-clinical staff so they could help feed and monitor residents during mealtimes. -However, meal observations revealed staff were not supervising R77 when he was eating (see observations above).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interview, the facility failed to ensure menus were followed to meet the resident's nutritional needs. Specifically, the facility failed to follow correct portions sizes to ensure adequate nutrition was provided to the residents. Findings include: I. Record review The menu extensions were provided by the Dietary Manager (DM) on 4/10/25 at 4:02 p.m. The menu extensions revealed in pertinent part: -A 1/2 cup serving of seasoned couscous to residents who were prescribed a regular diet, mechanical soft diet and therapeutic diets; -A 1/2 cup serving of pureed seasoned couscous to the residents who were prescribed a pureed diet; -A 1/2 cup serving of [NAME] vegetable blend regular, mechanical soft and therapeutic diets; and, -A 1/2 cup serving of the pureed [NAME] vegetable blend. II. Observations During a continuous observation of the lunch meal on 4/9/25, beginning at 12:01 p.m. and ending at 1:00 p.m. , Dietary Aide (DA) #1 used the following scoop sizes: -A #12 scoop (1/3 cup) for the seasoned couscous for regular, mechanical soft and therapeutic diets; -A #12 scoop (1/3 cup) for the pureed seasoned couscous; -A grey slotted spoon (1/2 cup) for [NAME] vegetable blend regular, mechanical soft and therapeutic diets; and, -A #12 scoop (1/3 cup) for the pureed [NAME] vegetable blend. From 12:22 p.m. to 12:35 p.m. when DA #1 served residents the [NAME] vegetable blend, she filled the #12 scoop (1/3 cup) half to three-quarters full. She did not fill the #12 (1/3 cup) scoop full. DA #1 said she was running out of vegetables in her steam table container. -However, the menu extensions indicated the residents should have received a 1/2 cup scoop of vegetables (see record review above). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:35 p.m. DA #1 put approximately 1/8th of a cup of vegetables onto a plate and said that's all she wrote, as the vegetable blend steam table container was empty. At 12:38 p.m. a container of the [NAME] vegetable blend was delivered. From 12:38 p.m. through the end of service, DA #1 served heaping spoonfuls of the vegetable blend. At 12:58 p.m. DA #1 prepared a mechanically soft texture plate by scooping two #12 scoops of mechanically soft meat and one heaping 1/2 cup scoop of vegetable blend before serving it to the resident. DA #1 said the meal was supposed to include couscous as well, but she had run out of the couscous, so she was just going with it. -The #12 scoop (1/3 cup), measuring 2.67 ounces (oz), was 1.33 oz less than the 1/2 cup (4 oz) specified on the menu extension sheet for the seasoned couscous, pureed seasoned couscous and pureed seasoned vegetable blend. B. Staff interviews The DM was interviewed on 4/10/25 at 1:35 p.m. The DM said DA #1 should have been serving a full 1/2 cup scoop of vegetables for each plate. The DM said DA #1 must have thought she was going to run out of vegetables, so she was nervous and overthinking the issue. The DM said the dietary staff were incorrect in using the #12 scoops for each menu item, as they should have been using the #8 (1/2 cup) scoop.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen and one of two nourishment refrigerators. Specifically, the facility failed to: -Ensure safe and appropriate storage of food items in the nourishment room refrigerators; -Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination in the main kitchen; and, -Maintain a clean and sanitary kitchen to prevent the harborage of pests. Findings include: I. Failure to safely and appropriately store food items A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 4/17/25. It revealed in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of seven days. The day of preparation shall be counted as day one. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (3-501.17) The Hormel Code Date and Handling Information 2022, retrieved from https://www.hormelhealthlabs.com/wp-content/uploads/HHL-Code-Date_Handling-Sheet-11_2022.pdf on 4/17/25. It revealed in pertinent part, Hormel Vital Cuisine Might Shakes, Great Shake Plus, and Nutritious Juice Drink, Shelf Life: unopened: 15 months frozen, refrigerated: 14 days thawed, bedside: up to two hours. B. Observations On 4/7/25 at 9:16 a.m., the following items were observed in the main walk-in refrigerator: -One opened container of half and half, unlabeled and undated; -Three pitchers of lemonade, unlabeled and undated; and, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A plastic bag containing multiple hotdogs and hamburger patties, unlabeled and undated. On 4/8/25 at 1:16 p.m., the following items were observed in the Pinion unit nourishment refrigerator: -An opened jar of sugar-free peach preserves, undated; -A carton of caramel macchiato iced coffee, with an open date of 2/22/25 and an expiration date of 11/29/24; -Four thawed cartons of Mighty Shake (oral nutritional supplement), with a date of 3/12/25; and, -Three thawed cartons of Mighty Shake with dates of 3/8/25, 3/4/25 and 3/15/25. On 4/8/25 at 1:16 p.m. an opened bottle of grape jelly, dated 1/9/25, was sitting on the Pinion nourishment room counter with a container of bread and a jar of peanut butter. The grape jelly was room temperature, and instructions on the bottle ready to refrigerate after opening. On 4/9/25 at 10:39 a.m. two opened bottles of grape jelly were sitting on the main kitchen food preparation counter with a jar of peanut butter. The grape jelly was room temperature and instructions on the bottle ready to refrigerate after opening. C. Staff interviews The Dietary Manager (DM) was interviewed on 4/7/25 at 9:35 a.m. The DM said the hotdogs and hamburgers were leftovers from the night before (4/6/25). The DM said the undated lemonade pitchers were from the night before (4/6/25) and the undated half and half container was from that morning (4/7/25). The DM said there was a new dietary aide who served the beverages and was still being trained. The DM said the kitchen staff usually kept leftovers for three to five days before throwing it away. The DM was interviewed a second time on 4/10/25 at 1:35 p.m. The DM said one of the dietary aides went through the nourishment refrigerators throughout the facility, checked their temperatures and went through the refrigerator contents once per day. The DM said the dietary aide recorded the temperatures of the refrigerators daily but did not record that he had gone through the contents of the refrigerators. The DM said Mighty Shakes should be thawed the day they were to be consumed. The DM said she thought the nursing staff were not diligent in looking at the expiration dates for items brought in by the residents or their families. II. Failed to ensure ready-to-eat foods were handled in a sanitary manner A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 4/17/25. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301.11) B. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation of the lunch meal service on 4/9/25, beginning at 12:01 p.m. and ending at 1:00 p.m. the following was observed: At 12:46 p.m. Certified Nurse Aide (CNA) #7 entered the Pinion unit nourishment room and said she needed to make a sandwich. CNA #7 retrieved a plastic bag of bread, grabbed two slices of bread with her bare hands and placed them on a plate. CNA #7 applied jelly to one slice of bread using a knife, then applied peanut butter to the other slice of bread. CNA #7 used her bare hands to close the sandwich and then used her bare hand to stabilize the sandwich as she cut it in half. C. Staff interview The DM was interviewed on 4/10/25 at 1:35 p.m. The DM said ready-to-eat foods should be handled with gloves after performing hand hygiene. The DM said the instance of the CNA preparing the sandwich with her bare hands should not have happened. III. Maintain a clean and sanitary kitchen to prevent the harborage of pests A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 4/17/25. It revealed in pertinent part, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by using methods, if pests are found, such as trapping devices or other means of pest control and eliminating harborage conditions. (6-501.111) Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. (6-201.11) In food establishments in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be covered and closed to no larger than one millimeter. The floors in food establishments in which water flush cleaning methods are used shall be provided with drains and be graded to drain, and the floor and wall junctures shall be covered and sealed. (6-201.13) B. Observations On 4/8/25 at 1:16 p.m. the window in the Pinion unit nourishment room was open approximately eight inches and did not have a screen on the window. The window lead to the resident smoking patio. On 4/9/25 at 10:39 a.m. during a follow-up tour of the main kitchen, the following was observed: -The window in the main kitchen was open approximately four inches and did not have a screen; -The dishwashing area floor had an area of several square feet covered with standing water; -The food preparation area had several tiles that were cracked or missing; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was a gap approximately two inches wide between the floor and the wall in the dishwashing area; -Several holes in the back wall of the dishwashing area; -The bottom five inches of the wall in the dishwashing area had dirt accumulated on it; -A glue trap was positioned below the dishwasher which contained thirteen dead cockroaches; and, -A glue trap was in the trash can next to the dishwashing area which contained more than fifteen dead cockroaches. On 4/9/25 at 12:12 p.m. the following was observed in the Pinion unit nourishment room: -The baseboard was separated from the wall with a gap of approximately 1.5 inches and when pressed, two ants came out from behind the baseboard; -An ant was observed running along the edge of an empty plastic container below the steam table; and, -A hole in the wall below the handwashing sink, approximately twelve inches wide by six inches tall. On 4/10/25 at 12:50 p.m. the glue trap under the dishwasher was no longer in place. C. Staff interview The DM was interviewed on 4/9/25 at 10:52 a.m. The DM said the kitchen staff did regular maintenance in the dishwashing area and used a squeegee to push any spilled water into the drain. The DM said the building was older, and any standing water was from water spilling while the kitchen staff were washing dishes. The DM said the windows in the kitchen should not be open. The DM said the facility staff needed to install the window screens and air conditioning units in the kitchen and satellite kitchen. The DM was interviewed a second time on 4/10/25 at 1:35 p.m. The DM said the facility's pest control company installed the glue trap below the dishwasher as a preventative measure and had just serviced the building a few weeks prior. The DM said there were cockroaches on the glue trap because of the trap's proximity to the drain. The DM said she had not seen any cockroaches in the food preparation areas. The DM said the staff may have thrown the glue trap away the night prior as they were cleaning the dishwashing area. The DM said the maintenance staff were aware of the holes in the walls of the dishwashing area and that there were active work orders for them. The DM said the kitchen maintenance work was all in progress. The DM said she was not aware of the hole in the wall below the handwashing sink in the Pinion unit nourishment room. -Pest control records and maintenance records were requested on 4/10/25 at 6:01 p.m. but were not received.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standard and principles that applied to individuals providing services in the facility for one (#78) of four residents reviewed for hospice services out of 37 sample residents. Specifically, the facility failed to ensure the hospice agency's notes were easily accessible to the facility staff and had consistent communication and documentation of hospice care visits and updates. Findings include: I. Facility policy and procedure The Hospice Program policy, undated, was provided by the Nursing Home Administrator (NHA) on 4/7/25 at 11:01 a.m. It read in pertinent part, When a resident has been diagnosed as terminally ill, the director of wellness will contact a hospice agency and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participate in the hospice program and to review available hospice (services) with the resident and/or responsible party. The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which includes, designation of a hospice registered nurse to coordinate the implementation of the plan of care, and provision of substantially all core services that must be routinely provided directly by the hospice associates and cannot be delegated to the community as outlined in current hospice regulations. II. Hospice Agreement The hospice agreement, dated 1/14/25, was provided by the NHA on 4/10/25 at 3:50 p.m. The agreement read in pertinent part, Hospice and the facility shall each maintain complete and detailed clinical records concerning each resident receiving facility services and hospice services under the agreement in accordance with prudent record-keeping procedures and as required. Each clinical record shall complete, promptly and accurately document all services provided to, and events concerning each resident, including evaluations, treatments, and progress notes. Hospice and the facility shall have each entry made for services provided to be signed by the person providing the services. Each record shall be readily accessible and systematically organized to facilitate retrieval by either party. II. Resident #78 A. Resident status R78, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included high blood pressure, psoriatic arthritis (inflammatory disease affecting skin and joints), depression, anxiety, dementia, history of neck and left femur fracture, stage 3 pressure ulcer and senile degeneration of the brain (decline in cognitive function). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/25/25 minimum data set (MD) assessment revealed the resident had a short-term and long-term memory problem and his cognitive skills for daily decision making were severely impaired per staff assessment. The resident was dependent on staff for hygiene, bathing, transfers and repositioning in bed. The MDS assessment revealed R78 was receiving hospice services. II. Record review The hospice plan of care, dated 1/15/25, was provided by the NHA on 4/10/25 at 11:32 a.m. The hospice plan of care documented the resident's personal hygiene was to be maintained. Pertinent interventions included care was to be completed by a hospice Certified Nurse Aide (CNA) that included CNA visits twice a week to provide a shower, shampoo, shave, mouth care, assist with dressing and undressing, nail care (file only), and skin observations. R78's hospice binder, was retrieved from a locked room and provided by Assistant Director of Nursing (ADON) #1 on 4/9/25 at 2:20 p.m. The hospice binder contained weekly visit verification forms signed by the hospice nurses. CNA visit notes were present in the binder from a 1/17/25 joint visit with a hospice nurse. -However, no other CNA notes, verification of hospice CNA visits or provisions of activities of daily living (ADL) care by hospice for the resident were present in R78's hospice communication binder or electronic medical record. Hospice nursing assessments were not present in the resident's hospice binder or electronic medical record (see facility follow up below). III. Staff interviews Licensed Practical Nurse (LPN) #2 was interviewed on 4/10/25 at 11:15 a.m. LPN #2 said the hospice staff saw R78 every Tuesday and Thursday. LPN #2 said the hospice staff checked in with the nurse upon arrival and after providing care for R78. LPN #2 said the hospice staff also provided R78 his shower. LPN #2 said she had not noticed that the hospice staff were not coming according to planned visits. LPN #2 said a hospice nurse and hospice CNA might come the same day or sometimes two nurses came the same day. LPN #2 said a hospice nurse had asked for the facility's hospice binder last week but the hospice staff did not usually ask for the hospice binder. LPN #2 said hospice staff could ask any staff person at the facility for the hospice binder, but she had only been asked for the hospice binder once. Certified Nurse Aide (CNA) #1 was interviewed on 4/10/25 at 11:25 a.m. CNA #1 said hospice staff were frequently at the facility and provided showers twice a week to R78. The Social Services Director (SSD) was interviewed on 4/10/25 at approximately 9:00 a.m. The SSD said that the facility and hospice team met monthly to make sure residents' needs were met and the facility invited the hospice team to the care conferences for the residents assigned hospice care. The SSD said ADL care was the primary responsibility of the facility and hospice was to provide additional ADL support. The SSD said R78's showers were the primary responsibility of the facility staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON #1 was interviewed on 4/10/25 at approximately 9:00 a.m. ADON #1 said hospice CNAs were supposed to come twice a week to see R78 and the hospice CNAs checked in with the nurses when they arrived. ADON #1 said the facility did not have the hospice CNA notes for R78 and were in the process of acquiring those (during the survey). IV. Facility follow up The Health Information Manager (HIM) provided R78's hospice notes on 4/10/25 at 12:57 p.m. (during the survey). A review of R78's hospice notes revealed a 2/6/25 hospice note that documented that a care conference took place on 2/5/25 without hospice being notified and hospice staff reinforced with the facility staff to include hospice in future care conferences. The hospice notes did not include documented visits twice a week by a hospice CNA.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47151 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance and performance improvement (QAPI) program committee failed to identify and address concerns related to accidents and safety of residents, which rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely. Findings include: I. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct F689 Accidents Hazards During the recertification survey on 5/23/24 F689 was cited at a L level scope and severity, immediate jeopardy to resident health or safety, widespread. During the abbreviated survey on 12/11/24 F689 was cited at a L level scope and severity, immediate jeopardy to resident health or safety, widespread. During the recertification survey on 4/25/25 F689 was cited at a J level scope and severity, immediate jeopardy to resident health or safety, isolated. F867 Quality Assurance Program During the recertification survey on 5/23/24 F867 was cited at a F level scope and severity, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. During the abbreviated survey on 12/11/24 F867 was cited at a F level scope and severity, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. During the recertification survey on 4/25/25 F867 was cited at a F level scope and severity, no actual harm with potential for more than minimal harm that is not immediate jeopardy, widespread. II. Cross-reference citation Cross-reference F689: The facility failed to provide appropriate supervision at meal times for R77, who had a history of choking. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's failure to provide supervision and assistance at meal times for a resident with a history of choking created a situation where a serious outcome was likely to occur and created an immediate jeopardy situation. III. Staff interviews The Nursing Home Administrator (NHA) was interviewed on 4/10/25 at 4:30 p.m. The NHA said the facility held a monthly QAPI meeting. The NHA said the facility team members, including the interdisciplinary team (IDT), also met daily and discussed potential risks to residents. The NHA said each day during the daily meeting, the team reviewed resident risks identified, how the risks were monitored and the expected outcome. The NHA said the facility developed corrective actions for identified risks that resulted from a collaborative discussion with the IDT. The NHA said there was a documentation binder that contained the problem that was identified, a system put in place or improved upon and how that situation was monitored. The NHA said each day any new issue that was identified was monitored. The NHA said a facility consultant performed an additional review of the facility's plan of correction. -However, the facility failed to identify R77 was not assisted and monitored during meal times, according to his care planned interventions, to ensure R77 did not choke.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, interviews and record review, 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 disease. Specifically, the facility failed to: -Ensure enhanced barrier precautions (EBP) were followed for R45 and R78, -Ensure proper hand hygiene was followed during wound care for R78, -Ensure housekeeping staff followed appropriate hand hygiene processes when cleaning resident rooms; and, -Ensure high touch surfaces in residents' rooms were cleaned. Findings include: I. EBP and hand hygiene failures A. Professional reference According to the Centers for Disease Control and Prevention (CDC), Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO)'s, (4/2/24), retrieved on 4/15/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens changing briefs or assisting with toileting, device care or use (central line urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). According to the CDC Clinical Safety, Hand Hygiene for Healthcare Worker (2/17/24), retrieved on 4/15/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids or contaminated surfaces and immediately after glove removal. B. Observations During a continuous observation of wound care on 4/9/25, beginning at 11:30 a.m. and ending at 12:00 p.m., the following was observed: Certified Nurse Aide (CNA) #5 donned (put on) gloves and turned R45 on his side. Registered Nurse (RN) #1 donned gloves and applied skin prep to R45's left heel deep tissue injury (DTI). -However, CNA #5 and RN #1 failed to don a gown prior to high contact care for R45. Nurse Manager (NM) #2 washed her hands and gathered supplies. NM #2 donned gloves and removed the old, dirty dressing covering R45's stage 3 pressure ulcer on the sacrum. NM #2 changed gloves and sanitized her hands after removing the dirty dressing. NM #2 cleansed the wound with saline and applied skin prep around the wound. She then applied calcium alginate soaked in Dakin's solution into the wound bed, covered the wound with a Mepilex dressing, dated and initialed the dressing. She changed gloves and performed hand hygiene between each step in the process. -However, NM #2 did not don a gown prior to starting wound care. During a continuous observation on 4/9/25, beginning at 2:37 p.m. and ending at 3:15 p.m., the following was observed: Assistant Director of Nursing (ADON) #1 and Licensed Practical Nurse (LPN) #1 entered R78's room with wound care supplies on a sterile field created on top of a movable table. ADON #1 washed her hands and donned gloves before beginning R78's wound care. LPN #1 also donned gloves and assisted ADON #1 by holding R78 in position. ADON #1 prepared the supplies on the sterile field and then used a sterile swab to remove the soiled packing from within R78's wound. -However, ADON #1 and LPN #1 failed to don a gown prior to starting R78's wound care. ADON #1 grabbed a new sterile swab, folded new packing material over the top and placed it on her sterile field. ADON #1 flushed the wound with saline (salt water), dabbed around the wound with sterile gauze and used the swab to press the new, clean packing into the wound. -However, ADON #1 failed to change gloves after removing the soiled packing from R78's wound. ADON #1 removed her gloves, washed her hands, donned new gloves, and applied a skin protectant around the wound. She placed sterile gauze over the wound and secured all four sides with paper tape. She removed her gloves, wrapped the supplies up within the sterile field, threw out the supplies and sanitized her hands. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Staff interviews ADON #1 and LPN #1 were interviewed together on 4/9/25 at 3:36 p.m. ADON #1 said normally, only gloves were worn when doing dressing changes, even if the wound was infected. She said EBP was worn when there were weeping wounds or wounds with resistant organisms. She said she did not think she had any training regarding EBP and was not aware that they were supposed to be wearing gowns for dressing changes. She said the wound doctor had not been wearing a gown for dressing changes. She said she should have changed her gloves after taking out the old packing. LPN #1 said she just started orientation at the facility and did not remember learning about EBP precautions. The Director of Nursing (DON), who was also the facility's Infection Preventionist (IP #1), and IP #2 were interviewed together on 4/10/25 at 10:18 a.m. The DON said he educated staff about EBP last summer (2024) when the policy came out. He said there were isolation carts for residents with catheters, wounds and other infections. He said the staff had used EBP for a previous resident that had a fungal infection, but somehow, they had forgotten about the other reasons for EBP precautions. He said EBP was needed for high-contact activities like bathing, dressing, incontinence care and linen changes for those residents. He said face shields were provided for residents with catheters to protect from splashing. He said he did not realize the focus had been lost until yesterday (4/9/25). He said he had started adding orders and care plans for EBP in the residents' electronic medical record (EMR). IP #2 said that she had already started re-educating staff about hand hygiene and EBP. IP #2 said the packet for new employees had information on EBP but somehow it had been forgotten. She said she would also address hand hygiene and EBP at the upcoming skills fair in August 2025. II. Housekeeping failures A. Professional reference 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) 113:104-114, retrieved on 3/21/25 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext, High-touch surfaces 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). 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. B. Observations (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Village - the Spearly Center	2205 W 29th Ave Denver, CO 80211

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 4/8/25, beginning at 9:13 a.m. and ending at 9:53 a.m., the following was observed: An unidentified Housekeeper (HK) sanitized her hands and donned gloves. She entered room [ROOM NUMBER], which was a triple occupancy room. The HK sprayed the bathroom toilet with Oxivir 5 sanitizer, wet a clean cloth with water from the sink and wiped the outside, rim of the toilet seat and sides. She scrubbed the inside of the toilet with the toilet brush and flushed the toilet. She wiped the top and outsides of the toilet again with the cloth and then placed the used cloth in a bag on her supply cart outside the room. -The HK failed to change gloves after cleaning a dirty area (the bathroom) before moving to a clean area (the bedroom). The HK then sprayed the mirror and sink with glass and multi-surface cleaner and wiped the area with clean cloths. She placed the used cloths in the bag on the cart and grabbed new ones. She cleaned the surfaces of the bedroom furniture, bed frames and lights for the three resident areas, changing cloths between steps. She cleaned the windows with a new cloth and window cleaner. She swept and then mopped the floor, using new mop heads for each resident area. At 9:53 a.m. the HK removed her gloves, exited room [ROOM NUMBER] and sanitized her hands. -The HK failed to clean and sanitize the high touch areas in room [ROOM NUMBER] including door knobs, light switches and the call lights. C. Staff interviews The Maintenance Director (MTD) was interviewed on 4/10/25 at 3:45 p.m. The MTD said it was necessary that the housekeeping staff changed their gloves before entering each room for cleaning. He said the staff should remove their gloves before leaving the room and wash or sanitize their hands afterward. The MTD said the housekeeping staff required high touch surfaces like call lights and door knobs to be cleaned at least twice per week unless the resident had an infection. He said he just learned today that gloves should be changed twice during a room clean, so he planned to do education on that.