STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065330	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor View Care Center	7991 W 71st Ave Arvada, CO 80004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37166 Based on observations, record review and interviews, the facility failed to ensure residents were treated with dignity in two out of four dining rooms. Specifically, the facility failed to: -Ensure an adequate system was in place to provide meal service in a timely fashion to residents waiting to be served their meals in the Aspen and Pine Ridge dining rooms, which resulted in some residents at the same table receiving their meals 40 to50 minute after other residents; and, -Ensure residents were treated with respect and dignity by staff in the dining rooms, including engaging with residents and addressing residents by his/her preferred name. Findings include: I. Facility policies and procedure The Quality of Life - Dignity policy, revised February 2020, was requested and received from the nursing home administrator (NHA) on 7/30/24. It read in pertinent part, Residents are treated with dignity and respect at all times. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice. The Assistance with Meals policy, revised March 2022, was requested and received from the nursing home administrator (NHA) on 7/30/24. It read in pertinent part, All residents will be encouraged to eat in the dining room. Residents who can not feed themselves will be fed with attention to safety, comfort and dignity, for example, not standing over residents while assisting them with meals and keeping interactions with other staff to a minimum while assisting residents with meals. II. Dining room meal times The posted meal times for the facility's dining rooms were scheduled to begin as follows: breakfast began at 6:45 a.m., lunch began at 11:30 a.m. and supper began at 4:20 p.m. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Aspen dining room observations During a continuous observation of the lunch meal in the Aspen dining room on 7/24/24, beginning at 11:54 a.m. and ending at 12:53 p.m., the following observations were made: At 11:54 a.m. eight residents were present and seated at tables in the dining room. One of the residents spilled water that ran all over the table and the floor. -No staff were present in the dining room and the water spill went unnoticed. At 12:00 p.m. lunch meal trays were delivered on a cart to the dining room by the dietary staff. At 12:04 p.m. staff started to pass the lunch meal trays to the residents seated at the tables. At 12:08 p.m the spilled water was noticed by an unidentified certified nurse aide (CNA) who cleaned up the spill. Another unidentified CNA was overheard telling two other staff members You guys will be feeding them (referring to residents) today before leaving the dining room. At 12:14 p.m. one of the CNAs was standing up next to a resident and assisting her with eating lunch. -The CNA failed to sit down next to the resident while assisting her to eat her lunch. At 12:20 p.m. five of the eight residents present in the dining room had received their meals. At 12:24 p.m. more meal trays were delivered to the Aspen dining room, however the lunch meal trays were for residents who chose to eat in their rooms and not for the three remaining residents in the dining room who had not yet received their meals. At 12:44 p.m. a third cart of lunch meal trays was delivered to the Aspen dining room. The three other residents in the dining room received their lunch meals, 40 minutes after lunch service began and at least 20 minutes after the other five residents had received their meals. At 12:53 p.m.one of the residents at the front right dining room table was heard asking if she could have toast. CNAs walking by the table ignored her request. A resident who was sitting next to her at the table said They told me they don't make toast. Staff members in the middle of the dining room were discussing another resident and were overheard saying She already ate, all she wanted was a sandwich and we offered her everything. -The staff members did not refer to the resident by name. During a continuous observation of the lunch meal in the Aspen dining room on 7/25/24, beginning at 12:00 p.m. and ending at 12:52 p.m., the following observations were made: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:00 p.m. The first lunch meal trays were delivered on a cart to the dining room. Two of the eight residents in the dining room received lunch meal trays from the first meal cart delivery. At 12:40 p.m. the second cart of meal trays was delivered to the dining room, however, the meal trays on the cart were for residents who were eating in their rooms and not for the remaining six residents in the dining room who had not yet received their meals At 12:52 p.m. the third cart of lunch trays was delivered to the Aspen dining room. The six other residents in the dining room received their lunch meals, 52 minutes after the other two residents in the dining room had received their meals. During a continuous observation of the lunch meal in the Aspen dining room on 7/29/24, beginning at 12:01 p. m. and ending at 12:47 p.m., the following observations were made: At 12:01 p.m. a housekeeper pushed a resident in a wheelchair into the dining room and was overheard asking a CNA Where do you want her? The CNA responded Put her with (resident name), she gets along with her. -The housekeeper and the CNA failed to refer to the resident in the wheelchair by her name. At 12:06 p.m. the first lunch meal tray cart arrived in the dining room. One out of seven residents present in the dining room received a lunch meal tray. The other meal trays on the cart were served to residents who were eating in their room. At 12:09 p.m. a second meal tray cart was delivered to the dining room. One of three residents, who were sitting at the same table, were served their lunch meal. At 12:21 p.m. a third meal cart was delivered to the Aspen dining room. All of the lunch meal trays on the cart were for residents who were eating in their rooms. At 12:30 p.m. a fourth lunch meal tray cart arrived in the dining room. Four of the remaining residents in the dining room received their meals. One resident in the dining room, who was sitting next to a resident who had received her meal tray at 12:00 p.m., still had not received her lunch meal. At 12:39 p.m. a fifth meal cart of lunch trays was delivered. All of the meal trays went to residents in their rooms. At 12:46 p.m. an unidentified CNA sat next to the resident with the face mask who required assistance with eating and started assisting the resident (21 minutes after she had received her meal). The resident's mask was still touching her lower lip. The CNA began helping another resident on her other side as well as the resident with the mask. The CNA did not remove the resident's mask or lower it below her chin. At 12:47 p.m. a sixth cart of lunch meal trays was delivered to the Aspen dining room and the last resident in the dining room was served (41 minutes after the first resident received their lunch meal tray). IV. Pine Ridge dining room observations (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation of the lunch meal in the Pine Ridge dining room on 7/24/24, beginning at 11:31 a.m. and ending at 12:42 p.m., the following observations were made: The Pine Ridge dining room had two round tables which accommodated five residents each and bistro seating for two residents. From 11:31 a.m. to 11:40 a.m., nine residents were assisted to the dining room for meal time. Four additional residents were seated by 11:52 a.m., for a total of 12 residents seated in the dining room. At 12:04 p.m. the first meal tray cart arrived at the Pine Ridge dining room. Two meal trays were delivered to two residents in the dining room. No other residents received a meal tray. At 12:08 p.m. an unidentified staff member told a resident that the food was coming. At 12:22 p.m., five additional meal trays arrived on a cart and were passed to residents. At 12:30 p.m., 38 minutes after the last residents were seated, five residents did not have meal trays. Two residents from each of the two dining tables and one of the two residents seated at the bistro counter waited to receive their meal tray while the other seven residents in the dining room were eating their lunch. An unidentified staff member said to a resident who was waiting for their meal tray, You are getting sleepy waiting for your lunch huh. Between 12:31 p.m. and 12:42 p.m., the remainder of the lunch meal trays were delivered and at 12:42 p.m. the last resident seated at the bistro counter in the dining room received his meal tray, 50 minutes after the last resident was initially seated for lunch. -The facility failed to ensure residents seated at the same table were served their meals in a timely manner during the lunch meal. During a continuous observation of the lunch meal in the Pine Ridge dining room on 7/25/24, beginning at 11:15 a.m. and ending at 12:50 p.m., the following observations were made: At 11:42 a.m. eight residents were seated in the dining room with four residents each seated at the two round tables. At 11:45 a.m. Resident #38 was just brought to the dining room and seated at the bistro counter. Three additional residents were seated in the dining room for a total of twelve residents. All residents had drinks in front of them but no food. At 12:02 p.m. Resident #38 made a short, low groaning sound. Registered nurse (RN) #3 approached Resident #38 and asked her if she was okay. Resident #38 replied she was okay and RN #3 asked Resident #38 if she was getting hungry. Resident #38 replied yes she was. At 12:07 p.m. four meal trays arrived and were delivered to residents seated in the dining room. Resident #38 continued to make a short, low groaning sound while seated in the dining room. At 12:14 p.m. Resident #38 was sitting with her eyes closed in the dining room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:15 p.m. CNA #11 escorted a resident from the dining room and no other facility staff were present in the dining room. At 12:22 p.m. five more meal trays had been delivered to residents seated in the dining room. Three residents seated at the round dining table did not have a meal tray while the remainder of the residents in the dining room had received meal trays and were eating their lunch. At 12:37 p.m. three residents had not yet received a meal tray. A resident who received her meal tray first finished eating, while the resident seated next to her had not received a meal yet and watched her eat her meal. At 12:42 p.m a cart of additional meat trays was delivered to the dining room. At 12:49 p.m. the final resident without a meal tray was given her lunch. RN #3 set up her tray and said to the resident, You look hungry. -The facility failed to ensure residents seated at the same table were served their meals in a timely manner during the lunch meal. V. Main dining room observations During a continuous observation of the dinner meal in the main dining room on 7/30/24, beginning at 4:16 p. m and ending 5:54 p.m., the following observations were made:: At 5:04 p.m. CNA #9 was observed standing next to a table in the dining room. A resident was seated in her wheelchair next to CNA #9. CNA #9 was eating out of a clear plastic container while standing in the dining room during meal service. -Dietary aide (DA) #1 was interviewed at 5:05 p.m. DA #1 said CNA #9 was employed at the facility and assisted feeding residents at meal time. At 5:07 p.m. CNA #9 sat down at the table and set his cell phone on the dining room table in front of him. CNA #9 offered the resident a drink with his left hand while looking down at his cell phone on the table. CNA #9 continued to hold the drink glass in front of the resident while he looked at his phone for approximately 45 seconds. CNA #9 put down the drink glass and continued to look at his phone instead of looking at the resident and engaging with her At 5:14 p.m. CNA #9 was looking down at his phone on the table while sitting with the resident, not making eye contact with her or engaging with her. -The dietary manager (DM) was interviewed at 5:17 p.m. The DM confirmed CNA #9 was an employee of the facility and the DM asked if CNA #9 was on his phone again in the dining room. The DM said she told CNA #9 to get off his phone at lunch and he was not happy he was told to put his phone away. The DM said in the orientation for new employees, she reviewed staff should not have their personal cell phones in the dining room. The DM said CNA #9 was not a new staff member and did not have an orientation with her but she said he should still know cell phones were not allowed in the dining room. At 5:31 p.m. CNA #9 was observed checking his hands and not looking at or engaging with the resident during meal time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA #9 failed to assist and engage with the resident while assisting her during meal service. VI. Staff training The DON provided an inservice on 7/30/24 at 1:25 p.m. The course title was nursing meeting and dated 4/11/24. The description of the education included addressing weight concerns (of residents), dining services, meal orders and encouraging residents to come to the main dining room. CNA #9 signed the inservice on 4/11/24. -However, the inservice did not provide details that specifically addressed resident meal time assistance. VII. Staff interviews CNA #12 was interviewed on 7/30/24 at 10:35 a.m. CNA #12 said the residents could choose which dining room they preferred to dine in and what menu items they preferred to eat. CNA #12 said, after facility staff took resident meal orders, the orders were given to the dietary staff. CNA #12 said she was unsure why resident meal trays were served so far apart for one dining room instead of being served together. CNA #12 said the facility staff usually had the residents seated in the dining room around 11:30 a.m. for lunch (however lunch was served between 11:30 a.m. and 1:00 p.m.) CNA #12 said residents expressed frustration about waiting too long for their meal trays to be delivered and dietary staff were aware of the resident's concerns. The DM and the nursing home administrator were interviewed together on 7/30/24 at 11:00 a.m. The NHA said the timing of meal delivery was an issue the facility was working on. The NHA said the facility only sent a few trays to one dining room at a time so the food was served hot. The NHA said the CNAs spent three days with another staff member for their initial training. The NHA said resident meal assistance, as well as feeding the residents, was part of the CNAs initial training. The DM said the goal was for staff to be able to pass some meal trays before sending more so the food stays hot. The DM said the dietary staff did not always know where the residents preferred to eat and where to send the meal trays. The DM said meal service usually took almost an hour. CNA #9 was interviewed on 7/30/24 at 11:30 a.m. CNA #9 said he was a full time CNA and was working occasionally at nights and on the weekends. He said dining room assignments for CNAs were not clear as far as which CNA needed to present in which dining room. He said sometimes CNAs were told to go to the main dining room and sometimes they were to go to the small dining room. He said the facility had new agency staff coming daily and those staff members were not aware of the resident's preferences and had a tendency to ask questions about personal care in front of the residents. CNA #9 said the general rules of meal assistance were to sit next to the resident and assist the resident with the meal until the resident was finished eating. He said all residents should be referred to by name and personal care and needs should not be discussed in front of other residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #9 said the kitchen always delivered meal trays in random order and there was no system to who received the first meal or which resident received the last meal. Licensed practical nurse (LPN) #1 was interviewed on 7/30/24 at 11:45 a.m. LPN #1 said she was not sure if there was an order for meal tray delivery. She said the kitchen delivered the trays randomly and it was unclear if there was any system to it. LPN #1 said when staff assisted residents in the dining room they should refer to residents by name, be attentive to their needs and help residents until they were finished with the meal. The NHA and the director of nursing (DON) were interviewed together on 7/30/24 at 12:45 p.m. The DON said the facility provided a meal service education in April 2024 to encourage residents to come to the dining room and CNA assistance with meals. She said staff were talked to about not being on their phones. The DON said meal service was something the facility had been working on and they were trying to get residents into a type of seating arrangement. -However, the inservice did not provide details that specifically addressed resident meal time assistance (see staff training above). The NHA said a cart of meal trays was delivered to the Pine Ridge dining room, and then another cart of meal trays was delivered to a different dining room so the CNAs had time to get trays set up for residents and the residents were not waiting too long. The NHA said the facility was trying to improve socialization with residents at meal time and improve overall meal service. The NHA said the facility had not yet considered staggering the start times of meals in the different dining rooms. CNA #11 was interviewed on 7/30/24 at 2:00 p.m. CNA #11 said the residents sometimes expressed concern they felt hungry while waiting for lunch. CNA #11 said the staff did their best to offer residents a drink or something small to eat while waiting for meal trays to be delivered at mealtime. CNA #11 said the late arrival of lunch meals could disrupt the resident's afternoon schedules. CNA #11 said longer mealtimes made it difficult to manage if residents were eating and needed assistance and another resident had to use the restroom, which caused the staff to leave the dining room to assist a resident with continence care. CNA #11 said she was trained how to assist a resident at meal time and a personal cell phone should not be used while assisting a resident. CNA #11 said staff should be seated and make eye contact with the residents because it was respectful to the resident and helped the residents trust the staff. The DON was interviewed again on 7/30/24 at 5:24 p.m. The DON said while assisting a resident at meal time, staff should sit so they were at eye level with the residents. The DON said staff's hands should be clean, staff should talk to the resident, inform the resident what menu items were on their plates and cue or assist them to eat as needed. The DON said cell phones were not acceptable to use while assisting a resident at meal time, nor were conversations about other residents. The DON said residents should be discussed on the side and resident's personal matters should not be discussed in front of other residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interviews, the facility failed to honor resident choices for three (#56, #6 and #65) of five residents reviewed for activities of daily living (ADL) out of 51 sample residents. Specifically, the facility failed to: -Ensure Resident #56, Resident #6 and Resident #65 received two showers a week per their preferences; and, -Ensure Resident #65 was assisted with a leg catheter bag on Sundays when he was attending church. Findings include: I. Resident #56 A. Resident status Resident #56, age 79, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (decreased oxygen levels), chronic obstructive pulmonary disease (COPD) and dependance on supplemental oxygen. The 6/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required substantial maximal assistance with showers and did not reject the care. B. Resident interview Resident #56 was interviewed on 7/24/24 at 3:28 p.m. Resident #56 said she had not had a shower in a week. She said her preference was to receive two showers a week. She said there were new staff members working at the facility every day and they were not familiar with the shower schedule. She said the staff would come into her room and say they would come back. She said the staff never returned to her room to assist her with a shower. She said sometimes the staff said there was not enough staff so they could not help with showers. C. Record review The care plan, initiated 11/15/23, identified Resident #56 had impaired balance and limited mobility. Interventions included staff to assist with showers. -A review of the care plan revealed the care plan did not address Resident #56's current shower preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated on 5/24/24, revealed that the resident was resistive to bathing, and would decline showers and bed baths at times. Interventions included allowing the resident to make decisions about treatment regimens, providing a sense of control and if possible negotiating a time for showers so that the resident participated in the decision making process. A review of the certified nurse aide (CNA) shower task for July 2024 revealed Resident #56 was to receive showers on Tuesdays and Thursdays on the evening shift. -The shower logs for 6/23/24 to 7/26/24 revealed the resident received one bed bath on 7/6/24 (Saturday), and one shower on 7/10/24 (Wednesday). The resident refused care on 7/5/24 (Friday) and 7/12/24 (Friday). -Resident #56 was supposed to receive nine showers a month and she received only one. -Review of the progress notes from 6/23/24 to7/26/24 revealed no documented notes for resident refusals of showers. II. Resident #6 A. Resident status Resident #6, age 76, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included COPD and hypertension (high blood pressure). The 6/26/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required substantial/maximal assistance with showers and did not reject care. B. Resident interview Resident #6 was interviewed on 7/29/24 at 1:28 p.m. Resident #6 said she received showers inconsistently. She said her preference was to receive showers twice a week. She said the agency staff did not know what the shower schedule was and who was to provide showers. She said the staff frequently said they were understaffed and could not provide showers. She said the facility used to have a shower aide, but with the new management, that position was eliminated. She said it was impossible to get a shower per her preference or at all. C. Record review The care plan, initiated 2/24/23, identified Resident #6 had impaired balance and decreased mobility. Interventions included assisting the resident with showers. -A review of the care plan revealed the care plan did not address Resident #6's current shower preferences. A review of the CNA shower task for July 2024 revealed the resident was to receive showers on Mondays and Thursdays on the day shift. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The shower logs for 7/1/24 to 7/30/24 revealed the resident received a total of five showers out of nine scheduled opportunities for showers. -Review of the progress notes from 7/21/24 to 7/30/24 revealed no documented notes for resident refusals of showers. III. Resident #65 A. Resident status Resident #65, age 82, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included hypertension, heart disease and diabetes. The 5/10/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required substantial moderate assistance with showers and did not reject care. B. Resident interview Resident #65 was interviewed on 7/25/24 at 1:28 p.m. Resident #65 said showers were provided inconsistently. He said his preference was to receive showers twice a week on assigned days. He said the agency staff did not know the shower schedule or who was to provide the showers. He said his showers were frequently skipped or not offered at all. Resident #65 said when he voiced his concerns to staff they would say they were too busy. He said every Sunday around 10:30 a.m. he went to church. He said he told staff that his regular catheter bag needed to be replaced with a leg catheter bag prior to attending church. He said the agency staff did not know what a leg catheter bag was. He said the prior Sunday when he was getting ready to go to church, the agency nurse did not know what a leg catheter bag was and it took 30 minutes to find someone who was able to help. He said every Sunday he had to find a nurse who knew what a leg catheter bag was. He said since there was no consistent staff working on the unit, his leg catheter bag was never ready in time for him to go to church. He said he was very frustrated with care. C. Record review The care plan, initiated 11/27/22, identified Resident #65 had impaired balance and decreased mobility. Interventions included assisting the resident with showers. -A review of the care plan revealed the care plan did not address Resident #65's current shower preferences. -The care plan for the urinary catheter, initiated on 11/27/22, did not mention resident's preference for a leg catheter bag on Sundays for church. A review of the CNA shower task for July 2024 revealed the resident was to receive showers on Tuesdays and Fridays on the day shift. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The shower logs for 7/1/24 to 7/30/24 revealed the resident received six out of nine scheduled opportunities for showers. -Review of the progress notes from 7/21/24 to 7/30/24 revealed no documented notes for resident refusals of showers. IV. Staff interviews Licensed practical nurse (LPN) #5 was interviewed on 7/30/24 at 10:45 a.m LPN #5 said the facility was understaffed especially on the Aspen unit where resident care was more heavy than on other units. LPN #5 said she was aware of Resident #65's preference for the leg catheter bag on Sundays. She said when she worked on the weekends she would help him with it. She said she did not know how agency staff could be aware of personal preferences since it was not documented anywhere. LPN #5 said on most days the facility did not have shower aides and CNAs were responsible for providing showers. She said she did not know shower preferences for any of the residents who had shower concerns. She said it was the CNAs responsibility to locate a binder at the nurses station and figure out who was due for showers. CNA #9 was interviewed on 7/30/24 11:47 a.m. CNA #9 said he used to be a shower aide at the facility but since a full time position as shower aide was eliminated with the new management, he was working as a CNA on various shifts. He said, on some rare occasions like today (7/30/24), he was assigned to work as a shower aide. CNA #9 said the facility used to have a schedule for showers where he and other CNAs were assigned to complete the showers. However, he said with new changes and new agency staff in the building, the old schedule did not work because agency CNAs would tell the facility staff what they would do and would not do. He said the rest of the staff would have to scramble and do extra work to provide the care that agency staff would not do. He said agency staff were frequently late or did not show up for work at all and that compromised the care for residents. He said he was certain many showers were missed for residents due to late arrivals and call offs by agency staff. Registered nurse (RN) #2 was interviewed on 7/30/24 at 11:59 a.m. RN #2 said she was an agency nurse and worked in the building on several occasions on different shifts, including weekends. She said she did not know about shower preferences as it was CNAs responsibility to provide showers. RN #2 said she did not know anything about Resident #65's routine on Sundays. She said her orientation to the unit consisted of shift to shift reports from nurses. She said all preferences residents could communicate directly to staff. She said when residents could not communicate, staff could call family and ask about preferences. CNA #11 was interviewed on 7/30/24 12:23 p m. CNA #11 said she was new to the unit and worked different shifts. She said she did not know when residents were to receive showers. She said she looked at the roster the facility provided to her before shifts and said showers or any specific resident preferences were not mentioned on that roster. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed in the presence of a nursing home administrator (NHA) on 7/30/24 at 5:20 p.m. The DON said the facility had identified that shower preferences were missed, and they were actively working on implementing a new system to ensure showers were provided per preferences. She said unit managers were working to ensure that agency staff had easy access to residents' preferences and would be updating it on the rosters that staff received at the beginning of the shift. The DON said she was not aware of Resident #65's leg catheter bag preference. The DON said the facility did employ agency staff and all staff were provided with the policies and expectations of the facility.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure one (#93) of three residents reviewed for nutrition received the care and services necessary to meet their nutritional needs and maintain their highest physical well-being out of 51 sample residents. Resident #93 was admitted to the facility for long term care on 3/27/24 with diagnoses of severe dementia with mood disturbance, hypothyroidism (underactive thyroid), depression and dysphagia of the oropharyngeal stage (food sticks to the mouth or throat or gets pocketed in cheeks). Upon admission (3/27/24), Resident #93 weighed 114.6 pounds (lbs). On 4/4/24 the facility placed the resident on restorative dining services, however, observations during the survey revealed the resident did not receive consistent assistance at meals. On 5/20/24, the resident weighed 112.6 lbs and on 6/20/24 the resident weighed 106 lbs. The resident sustained a 5.9% (6.6 lbs) weight loss from 5/20/24 to 6/20/24 in one month, which was considered severe. On 7/21/24 the resident weighed 100.5 lbs. At this time the resident sustained an additional 5.2% (5.5 lbs) weight loss from 6/20/24 to 7/21/24 in one month, which was considered severe. On 7/23/24 the facility implemented a four ounce house nutritional supplement. Due to the facility's failures to provide total assistance in a timely manner and consistently offer alternatives of equal nutritional value and accurately record her food intake, Resident #93 sustained a 9.1% (10.1 lbs) weight loss in three months, which was considered severe. Findings include: I. Facility policy and procedure The Weight Management policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 5/30/24 at 5:30 p.m. It revealed in pertinent part, Residents identified with weight change will be assessed by the interdisciplinary team (IDT), and further interventions will be implemented to minimize the risk for further weight change where possible and to promote weight stability. All residents will be weighed upon admission, then weekly or as indicated by physician orders. Results will be documented in the medical record. Residents will be screened by a registered dietitian (RD) or designee for their risk for weight change on admission, quarterly, annually, and with significant change of condition with completion of the minimum data set (MDS). Residents with weight variance (loss or gain) are reweighed. Significant/severe weight variance is defined as: 5 percent (%) in one month; 7.5% in three months; or 10% in six months (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Residents identified at risk for weight change will have interventions implemented to minimize the risk for additional weight change included in their plan of care. This may include supplements, RD evaluation and assisted dining. The following categories of residents should be weighed weekly unless otherwise indicated: residents with significant weight changes until weight is stabilized as defined in the policy; as determined by the physician, DON (director of nursing), RD (registered dietitian), or IDT teams discretion. The IDT meets weekly to review residents with identified weight changes, develops a plan, implements, evaluates, and re-evaluates interventions to minimize the risk for weight change. Nursing staff are responsible to communicate weight changes to the attending physician and resident's family. The nurse documents the notification in the medical record. Nursing staff is to notify food and nutrition services and the RD of a resident's weight change. The RD further assesses the resident to determine root cause of the weight change and makes recommendations to reduce or stabilize the weight change. Nursing staff or the RD are to notify the speech therapist (ST) if swallowing or chewing problems are suspected. II. Resident #93 A. Resident status Resident #93, age 85, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included severe dementia with mood disturbance, hypothyroidism, depression and dysphagia of the oropharyngeal stage. The 6/28/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required substantial/maximum assistance with showering and personal hygiene, and supervision and/or touching assistance with eating. -However, according to the 6/6/24 physician's order, the resident required total supervision and assistance with meals. The assessment documented the resident was 66 inches (five feet, six inches) tall, and weighed 106 lbs. It indicated the resident had weight loss (a loss of 5% or more in the last month, or 10% or more in the last six months). The resident had no signs or symptoms of a possible swallowing disorder. B. Observations During a continuous observation on 7/24/24, beginning at 12:04 p.m. and ending at 1:37 p.m., the following was observed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 12:10 p.m., Resident #93 was served a chicken salad sandwich, a cup of diced oranges and a glass of water. She took small sips of the water unassisted. Certified nurse aide (CNA) #3 sat down next to the resident and assisted her with two bites of the sandwich and then left the room at 12:24 p.m. -The resident did not touch her food until another CNA returned. At 12:39 p.m., Resident #93 took a few bites of her sandwich after prompting from CNA #3. CNA #3 left the resident. At 12:55 p.m. Resident #93 tried to eat her diced mandarin oranges by picking up the cup of oranges and sipping the fruit and juice from the cup. She spilled the juice from the cup, but was unable to get any mandarin oranges in her mouth. -No staff member assisted the resident in her attempts to eat her mandarin oranges. At 12:57 p.m., Resident #92, who was sitting at another table, moved to Resident #93's table and tried to help her eat her oranges. Resident #93 took a bite from the spoon full of oranges and then Resident #92 returned to his table. -Resident #93 did not receive any additional assistance from staff members and was not able to feed herself. At 1:07 p.m., the resident's meal was taken away from her. She had eaten one-fourth to one-third of the sandwich and one quarter of the cup of oranges, -However, the amount of food Resident #93 ate, charted at 3:01 p.m., was recorded as 51 to 75%. During a continuous observation on 7/25/24, beginning at 11:57 a.m. and ending at 1:15 p.m., the following was observed: Resident #93 was assisted by a staff member to the dining room. She received an egg salad sandwich, a cup of tater tots, a piece of apple pie and a glass of water for lunch. At 12:57 p.m. Resident #93 was assisted by CNA #7. She ate two bites of her egg salad sandwich, a few tater tots and a few sips of water. The resident ate less than 25% of her meal and started tearing-up, breathing heavily and was confused. She coughed and then CNA #7 prompted her to go to her room and relax. Resident #93 said she was tired. -Resident #93 was not offered any alternative to her lunch or any additional drinks. Meal intake documentation at 11:00 a.m. and 11:32 a.m, read the resident consumed 76 to 100% of her meal. -However, observations revealed she consumed less than 25% of her meal. During a continuous observation on 7/29/24, beginning at 12:10 p.m. and ending at 1:15 p.m., the following was observed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 12:10 p.m., Resident #93 was assisted to the dining room. At 12:24 p.m., an unidentified licensed practical nurse (LPN) approached the resident's table and asked another resident if she wanted anything to drink and offered her choices, then she left. Resident #93 had no food or drink in front of her. Resident #93 cried out softly, Why didn't you ask me? I don't have anything. There were no staff nearby to hear Resident #93's question. When the staff returned, they did not ask Resident #93 what she would like to drink. At 12:25 p.m. Resident #93 received her lunch, which consisted of iced tea in a sealed cup with two handles, a peanut butter and jelly sandwich and a cup of diced peaches. Resident #93 sat at the table talking quietly to herself. There were no staff members assisting the resident with her meal. At 12:29 p.m., Resident #93 took one sip from her fruit cup and took one bite of her sandwich without assistance. At 12:45 p.m., CNA #1 sat down next to the resident and assisted her with her meal. At 12:54 p.m., CNA #1 asked Resident #93 if she was done eating and the resident said yes. CNA #1 asked the resident if she could drink some more tea. Resident #93 did not reply and did not drink any more. The resident's meal was removed from the table. The resident ate one-fourth of the sandwich, four diced peaches, and drank two or three sips of the tea. -The meal intake, documented at 3:18 p.m. indicated Resident #93 ate 26 to 50% of her lunch. During a continuous observation on 7/29/24, beginning at 5:41 p.m. and ending at 5:55 p.m., the following was observed: At 5:55 p.m. Resident #93 was finished eating. She had eaten one-fourth of the sandwich, one-third of the cookie and drank approximately one-fourth of the water. -Meal intake documentation at 5:00 p.m. indicated the resident ate 26 to 50% of her dinner. During a continuous observation on 7/30/24, beginning at 9:15 a.m. and ending at 10:24 a.m., the following was observed: At 9:15 a.m. Resident #93 was assisted to the dining room. At 9:50 a.m., Resident #93 was served her breakfast which consisted of a banana, a glass of juice, one pancake and a glass of water. At 9:57 a.m., Resident #93 tried to drink her juice and it spilled. LPN #2 cleaned the spill and re-filled her cup. LPN #2 did not assist the resident with drinking. At 10:01 a.m., Resident #93 sat at the table and fiddled with the banana. LPN #2 sat across the table from the resident, occasionally interacting with her. LPN #2 was charting on her computer. She did not assist the resident with her meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 10:24 a.m., Resident #93 said she had enough. CNA #7 asked if she wanted more water. The resident said yes and had one sip. The resident consumed one-third of the pancake, approximately three-fourths of the banana and less than eight ounces of fluid between the water and juice. -However, meal intake documentation at 10:49 a.m. indicated the resident ate 76 to 100% of her breakfast. C. Record review The nutrition care plan, revised 3/29/24, revealed Resident #93 had the potential for nutritional problems related to her health status, secondary to her multiple disease processes. Interventions included explaining and reinforcing to the resident the importance of maintaining her diet ordered, encouraging the resident to comply, and explaining the consequences of refusal risk factors, monitoring weights as ordered, monitoring/documenting and reporting as needed any signs and symptoms of swallowing difficulties, refusal to eat, or if she appeared concerned during meals, obtaining food preferences and offering as able, offering food alternates of equal nutritional value, providing the ordered diet, monitoring and recording intake each meal and having the RD evaluate and make diet changes and recommendations as needed. Resident #93's weights were documented in the resident's electronic medical record (EMR) as follows: -On 3/27/24, the resident weighed 114.6 pounds; -On 4/5/2024, the resident weighed 115.5 pounds; -On 4/8/2024, the resident weighed 115.5 pounds; -On 4/9/2024, the resident weighed 112.6 pounds; -On 4/16/2024, the resident weighed 114.9 pounds; -On 4/23/2024, the resident weighed 110.6 pounds; -On 5/8/2024, the resident weighed 111.9 pounds; -On 5/13/2024, the resident weighed 110.2 pounds; -On 5/20/2024, the resident weighed 112.6 pounds; -On 5/28/2024, the resident weighed 111.2 pounds; -On 5/30/2024, the resident weighed 111.0 pounds; -On 6/7/2024, the resident weighed 107.8 pounds; -On 6/20/2024, the resident weighed 106.0 pounds; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 6/27/2024, the resident weighed 105.5 pounds; -On 7/7/2024, the resident weighed 100.5 pounds; -On 7/11/2024, the resident weighed 103.0 pounds; -On 7/21/2024, the resident weighed 100.5 pounds; and, -On 7/25/2024, the resident weighed 100.5 pounds. -Resident #93 lost 7 lbs (6.2%) from 5/20/24 to 6/20/24 in one month, which was considered severe. -The resident lost 7 lbs (6.5%) from 6/7/24 to 7/7/24 in one month, which was considered severe. -The resident lost 10.1 lbs (9.1%) from 4/23/24 to 7/25/24 in three months, which was considered severe. The 4/2/24 food preferences document revealed the resident had an excellent appetite and liked all food, with fish being her least favorite. She had not lost or gained weight recently. She drank milk. She liked dairy, vegetables, fruits, meat, protein, and carbohydrates like rice, potatoes, bread and cereal. She preferred water and was encouraged to drink four glasses per day. The document revealed her family brought her soda. On 4/4/24, a food and nutrition progress note revealed Resident #93 was underweight due to inadequate energy intake. The resident was referred to the restorative dining program for meal assistance, and RD #1 recommended a nutritional supplement, however the resident and her family refused the supplement as they preferred food and snacks brought by the family. The 5/22/24 and 5/29/24 weight meeting notes revealed Resident #93 continued to have weight loss. The resident ate 51 to 100% of most meals, which was a decrease in intake. She still had family-provided snacks in her room. The resident had recently reported jaw pain and was on antibiotics for a urinary tract infection. Both were resolved by 5/29/2024. The recommendations were to continue the restorative dining program and weekly weight meetings. The notes documented the resident's food preferences were discussed with the resident's daughter on 5/29/24. The 6/5/24 weight meeting note revealed Resident #93 was still on restorative dining and ate 76 to 100% of most of her meals the past week, occasionally less. She had snacks in her room and was on a regular diet with thin liquids. She received occupational therapy and had a new order for a speech therapy (ST) evaluation due to swallowing concerns. The 6/7/24 nursing progress note revealed the resident had a ST evaluation on 6/6/24 to address safe swallow function and diet tolerance, compensatory strategies and cueing. The 6/12/24 weight meeting note revealed that based on the resident's weight on 6/7/24, she had lost 3.2 lbs in one week. Resident #93 received restorative-dining assistance and generally consumed 51 to 100% of her meals. The note documented that daily menu items were discussed and the resident was told she could bring in fast food. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 6/24/24 restorative nursing note revealed the resident required varying degrees of verbal/tactile encouragement. She continued to need set up assistance and reminders to take sips of liquid after each bite. She consumed 75% of her food at each meal. The 7/3/24 weight meeting note revealed, based on the resident's weight on 6/27/24, she had a weight loss of 0.5 lbs in one week. The resident received physical therapy (PT) as of 6/26/24, and consumed 26 to 50% of most of her meals, occasionally more. The note documented she had snacks in her room and she continued to be monitored in weight meetings. The 7/10/24 weekly nursing note revealed the resident had no weight loss. -However, a review of the resident's recorded weights revealed she had lost five pounds between 6/20/24 and 7/7/24. The 7/11/24 progress note revealed the resident had lost five pounds in 10 days and another weight would be obtained for accuracy. The resident was re-weighed and weighed 103 lbs. The note revealed the resident continued to lose weight. Her intake was generally 26 to 50% of meals and 75% while receiving restorative nursing services. Resident #93 coughed with meals, causing herself to vomit and that it had been happening for over one month. The resident was eating a sandwich at the time and an RN assessessed the resident and determined the resident was not choking. The note documented this was a problem with the resident's teeth, but a speech evaluation was discussed. The 7/17/24 weight meeting note revealed the resident's weight had increased by 2.5 pounds in five days to 103 lbs. Weight meeting notes between 7/22/24 and 7/24/24 revealed the resident consumed 50% or more of her meals but was still losing weight. The resident's doctor and daughter were updated and a daily four ounce nutritional supplement was ordered on 7/24/24. The 7/29/24 restorative nursing note revealed Resident #93 needed total assistance with food intake, and continued verbal/tactile cueing to drink fluids at most meals. She ate 50 to 75% of her meals, and recommendations included continuing with the restorative nursing program and re-evaluating as needed. -Review of Resident #93's meal intake record revealed between 7/1/24 and 7/30/24, the resident consumed 50% or less of over half of her meals. The July 2024 CPO revealed the following orders: -Regular diet, easy to chew, thin liquids total supervision/assistance, no straws, use of two handed cups with a lid, and that softer textures may be ordered if appropriate, ordered on 6/6/24. -A four ounce house stock supplement once a day, ordered 7/23/24. A review of the July 2024 medication administration record (MAR) revealed Resident #93 was consuming an average of 27% from 7/23/24 to 7/29/24. III. Staff interviews (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	CNA #3 was interviewed on 7/30/24 at 10:31 a.m. CNA #3 said Resident #93 could not say what she wanted or liked to eat. She said, through trial and error, the facility determined she preferred sandwiches. She said sandwiches were easier for her to pick up and the restorative nurse aide who worked with her suggested them. She said Resident #93 needed varying amounts of assistance depending on her mood. She said the resident did not have a physical problem preventing her from being able to pick up her food, it was her mood that interfered. CNA #3 said if the resident was sad or anxious, she started crying, coughing and occasionally vomited, which prevented her from finishing eating. CNA #3 said staff talked to her to keep her occupied and happy, because then she would eat more. She said the resident's appetite had been pretty poor the last few weeks and thought she was now on an oral nutritional supplement. LPN #1 was interviewed on 7/30/24 at 12:53 p.m. LPN #1 said she noticed the resident needed assistance with eating and had asked staff to help her eat. She said if a resident could not state their food preferences, she would ask whoever was caring for them before they were admitted to the facility. The dietary manager (DM) was interviewed on 7/30/24 at 1:44 p.m. The DM said Resident #93's food and drink preferences changed depending on her level of confusion. She said she thought the CNAs chose her meals. The DM said, per the resident's EMR, she started taking a house supplement on 7/23/24 because she had a 7.5% weight loss of 11 lbs. She said the restorative nursing program had requested sandwiches for the resident to help her regain some independence with eating. The DM said she sometimes gave the resident handheld snacks, such as brownies and sweets. RD #2 was interviewed on 7/30/24 at 2:01 p.m. RD #2 said Resident #93 had lost about 10 lbs since April 2024, but was fairly stable until July 2024. RRD #2 said the provider and the resident's daughter were notified of the weight loss, a supplement was ordered and the resident started working with the restorative nursing program. She said originally, the resident refused the supplement, but after losing weight and talking to the resident's daughter, she agreed to take it. RD #2 said if the restorative nursing staff found something a resident liked, they offered that in addition to regular food items on the menu. She said Resident #93's food preferences were discussed at the care conference with the resident's daughter in April 2024. RD #2 said they learned the resident preferred home foods, grilled items, fast food and snacks that the family brought to the facility. RD #2 said the facility did not document consumption of family snacks because those were considered self-administered. The director of rehabilitation (DOR) was interviewed on 7/30/24 at 2:01 p.m. The DOR said when the weight loss was noticed in April 2024, the resident was added to the restorative program for eating and swallowing. She said for the past month (July 2024) the resident needed almost total assistance with eating and cueing, including showing her the motions and providing some touch-assist. She said sometimes the resident ate by herself, but other times she needed full assistance. She said the resident's meal intake stayed consistent between 50 to 75%. CNA #4 was interviewed on 7/30/24 at 3:03 p.m. CNA #4 said Resident #93 could point to pictures of food and say yes or no but could not say verbally what she wanted to eat. She said when she asked the resident what she wanted to eat, she offered the main entree first and showed her pictures so the resident could choose, before offering her a sandwich. She said she had never seen snacks in the resident's room and that her family was rarely there. She said she only saw Resident #93 snacking when occupational therapy was evaluating her. She said some of the CNAs had snacks that residents could eat, but she had not seen Resident #93 eating them and had never seen documentation of snacks eaten. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	CNA #5 was interviewed on 7/30/24 at 3:14 p.m. CNA #5 said the CNAs took meal orders and circled chosen items on the meal ticket. He said CNAs kept track of how much residents ate, especially residents who received meal assistance or were being watched for weight loss. He said if a resident ordered a sandwich, chips and jello for lunch and they only ate one-fourth of the sandwich, he would document that the resident ate 0 to 25% of the meal. He said if a resident ate that little of a meal, he would write a progress note and tell the nurse. He said if the decreased intake became a trend, it should be documented in the resident's EMR. LPN #3 was interviewed on 7/30/24 at 3:18 p.m. LPN #3 said she never saw snacks in the resident's room that the family had provided. She said she had seen the resident eat snacks before that were provided by one of the CNAs who had snacks for residents. LPN #3 said, in addition to the drinks Resident #93 had at meals, she encouraged fluids throughout the day and tried to give her water from her pitcher. She said the resident had not shown any signs of dehydration. RD #1 was interviewed via the phone on 7/30/24 at 4:16 p.m. RD #1 said she had only been employed at the facility for 24 hours so she did not know Resident #93 personally. She said she reviewed the resident's EMR and said the resident had weight loss of 7.5% since 5/8/24, which she considered significant. She said the resident was around 110 lbs to 111 lbs in April 2024, then had steady weight loss since May 2024. RD #1 said, given that information, she would have done a full assessment, requested the resident's food and liquid intake, and talked to nursing staff. She said if the resident was able, she would talk to the resident. She said she would have written a progress note, particularly if the weight loss occurred between quarterly assessments. RD #1 said in April 2024, the previous RD had recommended adding a nutritional supplement after dinner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observations, record review and interviews, the facility failed to ensure two (#56 and #21) of five residents reviewed for oxygen therapy was provided respiratory care consistent with professional standards of practice out of 51 sample residents. Specifically, the facility failed to: -Ensure Resident #56's CPAP (continuous positive airway pressure) machine was working appropriately and used as ordered by the physician; and, -Ensure Resident #21 was wearing oxygen as ordered by the physician. Findings include: I. Facility policy and procedure The Oxygen Administration policy and procedure, reviewed June 2023, was provided by the nursing home administrator (NHA) on 7/30/24 at 4:43 p.m. It read in pertinent part, Oxygen is administered under orders of the physician. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. -The policy did not include any pertinent information for the use of CPAP/biPAP (bilevel positive airway pressure) machines. II. Resident #56 A. Resident status Resident #56, age 79 , was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (decreased oxygen levels), chronic obstructive pulmonary disease (COPD) and dependance on supplemental oxygen. The 6/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was receiving oxygen therapy. -CPAP therapy was not documented on the assessment. B. Observations and resident interview (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 was interviewed on 7/24/24 at 3:11 p.m. Resident #56 was wearing oxygen via nasal cannula. At the bedside, a CPAP machine was observed on the table. Resident #56 said she had not used the CPAP machine for at least three months. She said the machine was broken. She said the staff were aware that it was broken. She said the staff would come and tell her that they would take care of it but no one did. She said the facility had new staff every day and she could not remember the names of all the staff who knew about the broken machine. C. Record review The oxygen therapy care plan, initiated 5/21/24, indicated Resident #56 required a CPAP machine for effective symptom management of COPD. Interventions included administering supplemental oxygen as ordered, ensuring the oxygen tubing was connected to the CPAP unit and verifying the liter flow prior to CPAP mask placement. -The care plan referred to machine BIPAP or CPAP interchangeably and the specific settings were not documented. -Review of the July 2024 CPO revealed Resident #56 did not have a physician's order for the use of a CPAP or BiPAP. Review Resident #56's physician progress notes between 5/1/2424 and 7/30/24 revealed a note on 5/20/24 that documented the resident was not using the CPAP machine because it was leaking water on her face when she was using it. The physician recommended service or replacement of the CPAP as soon as possible. -However, there was no additional documentation indicating the facility had attempted to service or replace the CPAP machine. D. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 7/25/24 at 2:30 p.m. CNA #10 said she did not know if the resident used a CPAP or BiPAP machine. She said she worked the morning shift and she had not observed the resident wearing the mask early in the morning. Registered nurse (RN) #2 was interviewed on 7/25/24 at 2:43 p.m. RN #2 said she did not know if the resident should or should not use the CPAP machine. She reviewed the physician's orders and said the resident did not have a physician's order for the CPAP machine. She said she was an agency nurse and did not know the resident well enough to know if the resident used the machine in the past. Licensed practical nurse (LPN) #1 was interviewed on 7/25/24 3:36 p.m. LPN #1 said she was a unit manager. She said she was new to the unit and today (7/25/24) was her eighth day of work on the unit. She said she remembered from the recent care conference that the resident was not using the CPAP machine but she did not know why and she did not ask the resident about it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 7/25/24 at 3:57 p.m. The DON said she did not know if the resident was using the CPAP machine. She reviewed the physician's orders and said the resident did not have a physician's order for the use of a CPAP machine. She said she was not aware that the machine was broken and did not know why it was not serviced since the physician's recommendation in May 2024. The DON said she would clarify the need for the CPAP machine with the physician and find out what needed to be fixed. 50690 III. Resident #21 A. Resident status Resident #21, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included dementia without mood disturbances, anemia (not enough oxygen in the cells to fuel the body), and a history of COVID-19 and stroke (blocked blood flow to the brain). The 6/7/24 MDS assessment documented the resident had severe cognitive impairment with a BIMS score of three out of 15. The resident required substantial assistance with personal hygiene, showering, bathing, toileting and dressing her lower body. She required moderate assistance for dressing her upper body and supervision and/or touching assistance with eating. She required substantial assistance for rolling in bed and for most transfers. The assessment documented the resident was on oxygen. B. Observations On 7/25/24 at 9:55 a.m. Resident #21's nasal cannula (tubing device that supplies oxygen through the nose) was not in her nose properly (only one of two nasal prongs was in her nose). At 10:07 a.m. the resident's nasal cannula was completely out of her nose. At 2:35 p.m. CNA #1 assisted the resident in her wheelchair to an activity. CNA #1 carried the portable oxygen on her back but the nasal cannula was not in the resident's nose. On 7/29/24 at 9:14 a.m. Resident #21 was lying flat in bed. The nasal cannula was not in her nose but was laying on her bed. At 11:29 a.m. Resident #21 was awake, lying flat in bed. The nasal cannula was not in her nose. C. Family member interview (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21's representative was interviewed on 7/30/24 at 11:05 a.m. Resident #21's representative said a few days prior to the survey, the resident called at night with a confusing question. He said he came to the facility the next morning and said the resident was more confused than normal. He said the resident's nasal cannula was not in her nose and was on top of the oxygen machine by the closet. The representative said he assumed that meant she did not get her oxygen overnight. He said he thought a CNA noticed in the morning and told the NHA because the NHA called the family later that day. He said there had been a few times he had noticed the nasal cannula had not been in her nose and the resident did not have the dexterity to put it back in herself. He said the staff did check her oxygen levels but he was not sure how often. The representative said the staff told him that even when she was not wearing her oxygen, her saturations were within normal limits. D. Record review The July 2024 CPO revealed the resident had a physician's order that indicated to administer oxygen at a rate of two liters per minute via nasal cannula every shift for hypoxia, ordered 4/12/24. The care plan, revised on 9/19/23, revealed the resident had oxygen therapy related to ineffective gas exchange. The oxygen was ordered at two liters per minute continuously. Interventions included changing her position often to ease movement and drainage of fluid in the lungs, positioning the resident to facilitate breathing and oxygenation by assisting her into an upright position whenever possible. The care plan revealed if the resident was on her side, her good side should be down (damaged lung facing up). The care plan indicated the resident should be monitored for signs and symptoms of respiratory distress and, if noted, reported to the physician. -The care plan did not address interventions to ensure the resident was wearing her nasal cannula and getting her oxygen as ordered. A review of the resident's electronic medical record (EMR) revealed between 7/1/24 and 7/29/24, the resident's oxygen saturations were documented three times per day and were 90% or above. On 7/12/24, they were not documented in the morning check. E. Staff interviews CNA #8 was interviewed on 7/30/24 at 12:44 p.m. CNA #8 said the CNAs and the nurses checked Resident #21's nasal cannula to make sure it was in. She said the resident sometimes took off the cannula to blow her nose and forgot to put it back in. She said the resident could not put it back in herself. CNA #8 said for the past three weeks she had been working at the facility and it had always been in. LPN #2 was interviewed on 7/30/24 at 12:56 p.m. LPN #2 said Resident #21 was on two liters of oxygen continuously but sometimes she took it off. LPN #2 said the resident could not put the nasal cannula back in her nose herself so staff frequently checked on her to make sure it was in. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 7/30/24 at 3:20 p.m. LPN #3 said the staff frequently checked on Resident #21 at night to make sure her nasal cannula was in because she had a history of removing it. She said she noticed it was not in her nose sometimes. She said if she noticed it was out of her nose she would put it back in. She said oxygen saturation levels were checked every shift for all residents on oxygen and more often if their oxygen had not been on consistently.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47536 Based on observations, interviews and record reviews, the facility failed to post nurse staffing information daily. Specifically, the facility failed to: -Post the daily number of hours worked for each nursing staff category in a clear and readable format. Findings include: I. Observations On 7/29/24 and 7/30/24 the daily staff information that was posted was dated 7/25/24. II. Staff interview The director of nursing (DON) was interviewed on 7/30/24 at 10:38 a.m. The DON said the posted nursing staff schedule information was posted near the front desk of the facility. She said the staff information should be posted daily. She said the posted schedule which was dated 7/25/24 was outdated. The DON said the scheduler was responsible for updating and posting the daily staff information. The scheduler was interviewed on 7/30/24 at 10:47 a.m. The scheduler said it was her responsibility to post the daily staff information and she had delegated the task to her assistant. The scheduler said she was unsure why the staff schedule information had not been updated after 7/25/24. She said she would follow up with her assistant and educate her assistant with the posting requirement.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%). Specifically, the facility had a medication error rate of 16.1%, or five errors out of 31 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 606-607, retrieved on 7/31/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Facility policy and procedure The Medication Administration policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 7/30/24 at 5:30 p.m. It read in pertinent part, Medications are to be administered in an accurate, safe, timely, and sanitary manner. Medication is to be given in compliance with physician orders. The Medication Time and Administration Guidelines were provided by the NHA on 7/25/24. The guidelines read in pertinent part, To better comply with our resident's rights, we have adopted the following guidelines for medication passing. Routine medications will be passed according to the following schedule: -EA: early am (6:00 a.m.); -AM: upon arising (6:00 a.m. - 11:00 a.m.); -MD: midday (11:00 a.m. - 1:00 p.m.); -PM: afternoon (4:00 p.m. - 7:00 p.m.); and, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-BT: bedtime (7:00 p.m.- 10:00 p.m.). Medications scheduled between 11:00 p.m. and 6:00 a.m. will be documented as time specific. III. Observations On 7/24/24 during a continuous observation, beginning at 9:30 a.m. and ending at 11:30 a.m., registered nurse (RN) #1 was observed passing medications to residents. At 9:30 a.m. RN #1 was administering medications to Resident #87. The medication administration record (MAR) for July 2024 read that Resident #87 was due for the following medications: -Lactaid 3,000 units to be administered at 7:30 a.m. for lactose intolerance; and, -Fluticasone propionate nasal spray, two sprays in each nostril to be given in the morning for allergies. RN #1 could not locate the appropriate dose of Lactaid medication in his cart. He went to the unit manager for help. While RN #1 was trying to locate the appropriate dose of Lactaid medication, he locked all other medications in his cart. At 10:45 a.m., after locating the correct dose of Lactaid, RN #1 returned to his medication cart, added the medication to the medication cup containing Resident #87's other oral medications and proceeded to the resident's room to administer the medications. He did not take the resident's fluticasone propionate nasal spray to the room with the other medications. RN #1 administered the medications and returned to his medication cart. -RN #1 administered Resident #87's Lactaid two hours and 15 minutes after the allowed administration time. -RN #1 failed to administer the nasal spray to Resident #87. On 7/29/24 at 9:23 a.m., licensed practical nurse (LPN #2) was observed during medication administration for Resident #97. LPN #2's medication screen listed three medications that were color-coded red, which indicated the medications were late (see interviews below). The late medications were as follows: -Celecoxib 200 milligrams (mg) two times a day for pain, scheduled at 8:00 a.m.; -Clobazam 20 mg tablet, give 40 mg two times a day for seizures, scheduled at 8:00 a.m.; and, -Lacosamide 50 mg two times a day for seizures, scheduled at 8:00 a.m. -LPN #2 administered the three medications at 9:23 a.m. (23 minutes after the allowed administration time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Staff interviews LPN #4 was interviewed on 7/24/24 at 10:05 a.m. LPN #4 said that when items were color-coded red on the medication administration record (MAR), it meant that something was late or missing. RN #1 was interviewed on 7/24/24 at 10:50 a.m. RN #1 said he was an agency nurse and this was his first day working on the unit. He said he did not know specific preferences for the residents and it took extra time for him to find out what the preferences were. He said, for example, he had to approach Resident #87 three times before he was able to administer her morning medications. RN #1 said initially Resident #87 said she would take her medications only with warm to hot water due to her tooth sensitivity. He said when he came back with warm water she did not like that he had mixed her miralax medication with the hot water and he had to remix the miralax in a separate cup and bring a fresh cup of hot water. He said because he had to approach Resident #87 three times with her medications, he forgot about her nasal spray. LPN #2 was interviewed during medication administration on 7/29/24 at 9:23 a.m. LPN #2 said she had a lot of medications to give and she was behind and did not want to be slowed down by being interviewed. The DON was interviewed on 7/30/24 at 5:14 p.m. The DON said all medications that were labeled as AM could be administered any time between 6:00 a.m. and 11:00 a.m. However, she said medications that were scheduled at a specific time should be administered as scheduled. The DON said because it was not possible to administer all medications at the exact scheduled hour, it was acceptable to administer medications one hour before or one hour after the documented scheduled time. She said she was not aware that medications were not administered on time. She said she would audit the medication administration to ensure all medications were administered on time. 37166

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47536 Based on record review and interviews, the facility failed to employ an infection preventionist (IP) who had completed specialized training in infection prevention and control. Specifically, the facility failed to have a qualified IP involved with the facility's infection prevention and control program. Findings include: I. Facility policy and procedure The Infection Control and Surveillance policy, dated 7/28/23, was provided by the nursing home administrator (NHA) on 7/23/24. The policy documented in pertinent part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is developed to address the facility-specific infection control needs, requirements identified in the facility assessment and the infection control risk assessment. The elements of the IPCP consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IPCP is coordinated and overseen by an IP specialist. II. Record review On 7/24/24 at 12:19 p.m. the NHA wrote in an email message that the facility did not have a designated IP and was recruiting to fill the position. III. Staff interview The director of nursing (DON) was interviewed on 7/29/24 at 10:25 a.m. The DON said the facility did not currently have a qualified IP. The DON said she and the unit nurse managers shared the duties and the responsibilities of the IP position, but they had not completed the required specialized education for the IP position.