STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	885 S Highway 50 Business Loop Olathe, CO 81425

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40467 Based on observations, interviews and record review, the facility failed to address and/or act promptly upon the grievances and recommendations during resident council on issues of resident care and life in the facility that were important to the residents. Specifically, the facility failed to ensure resident council concerns were addressed timely with interventions to resolve the resident's call light concerns. Findings include: I. Facility policy The Grievance policy, dated 5/8/23, was provided by the nursing home administrator (NHA) on 3/27/24 at 4:00 p.m. The policy read in pertinent part: To ensure that residents are forwarded their right to file grievances without discrimination or appraisal and such grievances shall be responded promptly and in written form. The administrator may assign the responsibility of investigating grievances and complaints to the appropriate department. Upon the receipt of a grievance and complaint report or complaint concern form, the social service director or designee will begin an exploration into the allegation/concerns. The appropriate department director will be notified of the nature of the complaint and that follow-up is necessary. Grievance and complaint investigation report must be filed with the administrator within five working days of the receipt of the grievance or complaint form. The resident or the person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 10 working days of filing the grievance or complaint. II. Group interview (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Five residents, (#6, #18, #25, #33 and #40) were interviewed during a group interview on 3/26/24 at 1:15 p. m. The residents were deemed alert and oriented by the facility. Two of the five residents expressed concerns with receiving care timely. -Resident #6 said she had to wait up to 45 minutes to use the restroom. She said she has had an accident because she had to wait too long for staff assistance. -Resident #25 said he had waited 30 minutes to use the restroom. III. Resident council minutes The review of the resident council minutes from December 2023 through March 2024 identified the residents in resident council had concerns regarding long call light times since December 2023. The concerns remained unresolved. The minutes did not identify how the facility was addressing the unresolved concern. The November 2023 resident council minutes read the social service director (SSD) told the council that if residents had any complaints or concerns she would provide them with a form. The December 2023 resident council minutes read the residents said they were having to wait for longer periods of time to receive care. According to the minutes, the residents felt long call light waits were usually between 5:00 p.m. and 7:00 p.m. The minutes read a grievance was filed for call wait times. The minutes did not identify how the facility planned to address the residents' call wait times. -The grievance form related to the residents' call light concerns was requested, however, the facility was unable to provide documentation to indicate a grievance form had been completed for the resident council concern. The January 2024 resident council minutes read residents felt they still had a slight wait time with their call lights. According to the January 2024 minutes, the group grievance regarding call wait times was not resolved. -The minutes did not identify how the facility addressed and was addressing the unresolved concern on call light wait times. The February 2024 council minutes read resident council stated call light wait times were beginning to improve and answered more promptly. The minutes read grievance regarding call light times was not resolved during the February 2024 council. -The minutes did not identify how the facility was addressing the ongoing unresolved concern. The March 2024 council minutes under new business read call lights were answered promptly; however, the review on the last two councils, the residents did not resolve the grievance on call lights. The March 2023 minutes under new business read resident council felt call lights were improving but did not feel their grievance regarding call light wait times should be resolved. -The minutes did not identify why the resident felt the call light grievance was not resolved. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The minutes did not identify how the facility was addressing the ongoing resident concern. IV. Staff education A 2/29/24 staff inservice form was provided by the facility on 3/27/24. The inservice topic was call light times. The form was signed by nine CNAs. The inservice was the provided intervention after the residents expressed and carried over call light concerns in the December 2023, January 2023 and February 2023 resident council. In March 2024, and after the nine staff were in-serviced on 2/29/24, the residents still did not feel the call light concern could be resolved. V. Staff interviews The nursing staff scheduler (NSS) was interviewed on 3/27/24 at approximately 10:00 a.m. The NSS said residents had come to her expressing they needed more help with care. She said the residents said they needed more assistance so they could timely use the restroom. She said most of the concerns were in the evening. She said the concerns were sporadic. She said the residents might have felt they needed more assistance in the evenings because during the day the management staff answered call lights. The social services director (SSD) was interviewed on 3/27/24 at 12:05 p.m. She said when she received a grievance she brought up the concern in the morning meetings with leadership. She said the week of 3/18/24 she identified an issue with the facility's grievance follow-up. She said the responsible department was not following up with the residents or correcting the issue. She said to fix the problem each department manager was going to touch base with the resident and see if the grievance was resolved. A three-check system was created to ensure the grievances were followed up on by the department head first, then the SSD and the NHA provided the final check. The nursing home administrator (NHA) was interviewed on 3/27/24 at 1:33 p.m. She said she and the SSD started looking at grievances last week (on 3/20/24) and identified the grievance system needed to be revamped. The NHA said she identified concerns were not being responded to in a timely manner, the responses were incomplete and/or the response did not resolve the concern. The NHA said when she was made aware of call light concerns, she could pull the call light report. She said the report was usually not pulled for the quality assurance and performance review meetings unless there was an identified problem. The NHA said she attended the resident council meetings when she was asked to attend the meetings. The NHA said the activity director shared the minutes with her each month but she had not looked at the minutes to know call light timing was an ongoing concern. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said with concerns addressed in resident council, a grievance form was started with activity director or designee, the grievance was shared with the SSD and then it would be reviewed in the interdisciplinary committee (IDT). The IDT determined who was best to address the concern. The grievance would be given to the appropriate department with an expectation of a 72 hour follow up. The NHA said she felt there was a lot of opportunity to improve the grievance process. She said there was a lack of accountability. The NHA said she had a lot of new members of management and she was not sure the team members understood the importance of addressing the concerns timely and accurately and returning the grievance forms. The NHA said the SSD said she had been struggling with the department's to return the grievance forms. The NHA said she would continue to work on oversight of the process.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on interviews and record review, the facility failed to ensure three (#23, #36 and #42) of four residents reviewed were free from abuse out of 26 sample residents. Specifically, the facility failed to ensure: -Resident #23 was free from physical resident to resident altercations/physical abuse by Resident #42; and, -Resident #36 was free from physical resident to resident altercations/physical abuse from Resident #42. Findings include: I. Facility policy and procedure The Abuse policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/27/23 at 6:10 p.m. The policy identified in pertinent part: (The facility) does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Providing a safe environment for the resident is one of the most basic and essential duties of our facility. According to the policy, abuse was defined as The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a care, of goods or service that are residents from abuse, necessary to attain or maintain physical, mental, or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. II. Incident of physical abuse of Resident #23 by Resident #42 A. Incident on 1/27/24 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/27/24 nursing progress note for Resident #42 read Resident #42 was involved in an altercation with another resident. There were no injuries. The 1/27/24 incident report was provided by the NHA on 3/26/24 9:25 a.m. The report identified the nurse was informed Resident #23 was slapped by another resident (Resident #42). The residents were separated and 15 minute checks on the residents were implemented. The residents were assessed and there were no injuries on either resident. The altercation was witnessed by certified nurse aide (CNA) #1. According to the incident report, the predisposing factor was wandering. The abuse investigation read on 1/27/24 at approximately 10:45 p.m., CNA #1 witnessed Resident #42 walk up to Resident #23 who was on the couch (in the common area). Resident #42 attempted to take Resident #23's hat from her. The CNA got up to intervene and at that time Resident #42 hit Resident #23 in the face. The CNA was able to separate the residents and call the nurse to assist. No injuries were noted and residents did not recall the incident and were both at baseline. The registered nurse (RN) was interviewed and identified Resident #42 refused her medications all day. The resident accepted her medication later that evening and was agitated. The report read Resident #23 was sleeping when Resident #42 approached her. The residents were speaking normally to each other when out of nowhere Resident #42 became upset and took Resident #23's hat. Resident #42 then extended her hand and slapped Resident #23. The incident was substantiated without injury. B. Resident #42 1. Resident status Resident #42, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnosis included unspecified dementia, unspecified severity, with other behavioral disturbance and Alzheimer's disease. The 2/1/24 minimum data set (MDS) assessment identified the resident had moderate cognitive impairment with a staff assessment for mental status. The resident had short and long term memory problems. Resident #42 had hallucinations and delusions. She had physical and verbal behaviors directed to others. The resident was identified to have other behavioral symptoms not directed toward others. The resident had rejections of care and exhibited daily wandering behaviors. The resident's functional ability on admission identified the resident did not have limitations of her upper or lower extremities. The resident did not require a mobility device. 2. Record review The verbal and physical aggression care plan, initiated on 10/4/22 and revised on 3/18/24, identified Resident #42 was at risk for resident-to-resident altercations related to verbal/physical aggression and dementia with behavioral disturbances. According to the care plan, the resident had a a history of being involved in resident-to-resident altercations. The resident's aggression was often unprovoked and unpredictable. The care plan directed staff to anticipate her needs. The care plan identified the following interventions: -Stop sign to be placed at resident's level on door to help prevent others from wandering into her room and staff to monitor. The care plan intervention was initiated on 7/28/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #42 enjoyed attending equine therapy and spending time with the facility pets. The care plan intervention was initiated on 10/4/22 and revised on 5/16/23. -Resident #42 was placed on frequent checks and closely watched by staff. The care plan intervention was initiated on 9/8/23 and revised on 9/13/23. -Provide one-on-one visits as needed if the resident was not able to be soothed. The staff may assist the resident of the unit or to a quiet/ less stimulated place until her mood was alleviated. The care plan intervention was initiated on 10/4/22 and revised on 3/14/24. -The resident would be evaluated for pain and constipation when the resident had an increase in agitation and excess pacing. The care plan intervention was initiated on 3/14/24. -Monitor Resident #42 for constipation daily. The care plan intervention was initiated on 3/14/24. -Monitor the resident for pain frequently throughout the day. The care plan intervention was initiated on 3/14/24. -A psychoactive medication pharmacy review would be conducted as needed. The care plan intervention was initiated on 3/14/24. -Staff was to be educated on anticipating needs and watching Resident #42 closely for agitation. The care plan intervention was initiated on 3/14/24. The behavior care plan, initiated on 11/19/21 and revised on 11/22/23, identified Resident #42 had behavior challenges related to her severe cognitive impairment. According to the care plan, The resident had exit seeking behaviors that caused the resident to become frustrated with her surroundings and others. The care plan read the resident was able to be redirected to safe tasks. Interventions included: anticipating her needs; behavior monitoring; provide opportunities for positive interaction; provide activities of interest and ability and praise positive interaction; and monitor the resident behavioral episodes and attempt to determine the cause. According to the care plan intervention, initiated 2/1/24, the resident had chronic pain which could increase her behaviors. The intervention directed staff to monitor her pain and ensure the resident took all her medications. C. Resident #23 1. Resident status Resident #23, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dementia, senile deterioration of the brain, glaucoma and presence of a cardiac pacemaker. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/11/24 MDS assessment identified Resident #23 had severe cognitive impairment with a BIMS score of three out of 15. The MDS assessment identified the resident did not have functional range of motion impairment with her upper or lower extremities. She was to ambulate independently and wandered daily. The resident had hallucinations, delusions and behaviors of verbal aggression. 2. Record review The secured unit care plan, initiated 6/1/23 and revised on 11/22/23, read Resident #23 required a secure neighborhood due to senile degeneration of the brain, dementia with agitation and psychotic disturbances. The cognition care plan, initiated 6/2/23 and revised on 11/22/23, read Resident #23 had impaired cognitive function/dementia or impaired thought processes related to impaired decision making. The resident was able to communicate her needs and wants verbally and nonverbally with simple communication. The behavior and wandering care plan, initiated 6/2/23 and revised on 11/22/23, read Resident #23 had a behavior problem of wandering and exit seeking. According to the care plan, staff were to monitor behavioral episodes and attempt to determine the underlying cause considering location, time of day, persons involved and situations. 3. Staff education The 1/30/24 in-service instructed the memory care unit nurses to attempt to administer medications (when Resident #42 was resting) before charting the resident was sleeping or refused. The in-service read staff should crush medications and give in a medium of choice to ensure the medications were and apply pain gel as ordered. Three nurses signed the in-service. III. Incident of physical abuse of Resident #36 by Resident #42 A. Incident on 3/10/24 The 3/10/24 nursing progress note read Resident #42 was pacing back and forth in the hall and was agitated on 3/10/24 from approximately 3:00 p.m. to 3:30 p.m. The activity assistant (AA) and the nurse witnessed Resident #42 walk past Resident #36 and smack the back of her head. Resident #36 was not injured. Resident #42 remained agitated another 40 minutes then settled down to rest in a chair. According to the note, attempts to redirect Resident #42 were ineffective. The resident was administered her medication which was effective. The 3/10/24 alert note for Resident #42 read Resident #42 smacked Resident #36 with the palm of her hand. Resident #36 said oh and Resident #42 continued to walk. There were no injuries involved in the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The abuse investigation read on 3/10/24 at approximately 3:22 p.m., residents were sitting in a group engaged in a bowling activity. Resident #36 was participating in the activity when Resident #42 walked up behind her and hit her on the back of the head with an open palm and walked away. No injuries were noted and neither resident recalled the incident during the investigation. According to the abuse investigation report, the incident was substantiated. D. Resident #36 1. Resident status Resident #36, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Alzheimer's disease, dementia, unspecified severity, with other behavioral disturbance and glaucoma. The 1/3/24 MDS assessment identified Resident #36 had severe cognitive impairment with a BIMS score of seven out of 15. The MDS assessment identified the resident did not have functional range of motion impairment with her upper or lower extremities. The resident used a walker for ambulation. The resident had behaviors of verbal and physical aggression. 2. Record review The secured unit care plan, initiated 1/23/23, read Resident #36 required a secure neighborhood due to her wandering without the ability to find her way back. The cognition care plan, initiated 10/4/23 and revised on 11/22/23, read Resident #36 had delirium or an acute confusional episode related to dementia. The resident allowed staff assistance and was easily redirected. The communication care plan, initiated 1/20/23 and revised on 1/31/23, read Resident #36 had communication problems related to dementia. The resident was very soft spoken and non-verbal the majority of the time and occasionally would speak in her native Japanese language. The resident was able to follow simple commands. 3. Staff education A 3/14/24 staff in-service was provided by the director of nursing (DON) on 3/26/24 at 12:26 p.m. The in-service read when Resident #42 was agitated, re-direct the resident from other residents to a less stimulating environment. Provide Resident #42 one-on-one support and anticipate her needs. Evaluate Resident #42 for pain and constipation. To reduce the risk of recurrence of resident to resident altercations, place Resident #42 on frequent checks and monitor her for an increase in agitation. The in-service was provided to the nurses, CNAs and an activity assistant (AA) who worked on the memory care unit. IV. Staff interviews The NHA, the DON and the memory care unit manager (UM) were interviewed on 3/26/24 at 9:25 a.m. The abuse investigations involving Resident #42 were reviewed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said Resident #23 was on the couch on 1/27/24 at 10:45 p.m. when Resident #42 walked up to her and took her hat. The residents exchanged words. The CNA on the unit saw Resident #42 take the hat and then slap Resident #23 in the face before the CNA could intervene. At the time of the incident, Resident #23 and Resident #42 were the only residents up and in the common area. The UM said Resident #23 usually preferred sleeping on the couch. There was no injuries or redness to Resident #23's face and the nurse said neither resident was upset. Both residents were placed on frequent checks for 72 hours with frequent observations. There were no significant changes with either resident after the incident The NHA said Resident #42 had declined her medications during the day on 1/27/24 but received her medications in the evening before the incident. The UM said Resident #42 would not always take her medications but she was more receptive since the incident. The NHA said the resident was on a new antipsychotic medication at the time of the incident and was adjusting to it. Resident #42's family member said the resident was suspicious of her medications. The UM said after the 1/27/24 physical altercation between Resident #42 and #23, she completed an education with the nurses on effective ways to give medications. She said medications could be crushed if deemed appropriate and placed in a medium of choice (apple sauce, pudding) The UM said a pain medication was added because a contributing factor could also have been pain related. The UM said she educated the staff to attempt to administer routine medications by gently waking Resident #42 if she was sleeping because the resident would wake up agitated. The NHA said the resident did take the medications in the evening so the medications were in her system at the time of the 10:45 p.m. incident. The UM said the resident had an order to crush the medications if needed since September 2023 but she would take the medications whole for some of the nurses. The nurses were reminded to crush appropriate medications to help in the administration of the medications on 1/30/24 which had helped improve the receipt of Resident #42's medications. The NHA said the other interventions were to focus on pain management. The resident had a chronic back injury. The UM said the resident had oral pain medications in place and topic gel. There had been no other incidents or concerns between Resident #42 and Resident #23 after 1/27/24. The resident to resident altercation between Resident #42 and Resident #36 on 3/10/24 was reviewed with the NHA, the DON and the UM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said Resident #42 walked behind Resident #36 when she was in a bowling activity and hit her. Resident #42 was not participating in the activity at the time but she was walking by. The nurse did not believe pain was a factor in the altercation and Resident #42 was receiving all her medications. The nurse witness statement read Resident #42 was agitated all day and was combative and verbally aggressive with staff. The NHA said during the investigation, the nurse and the AA felt the large bowling activity group was too stimulating in the common area for Resident #42 and caused her to act out. The NHA said another factor was the resident had not had a bowel movement in three days. The UM said the physician was contacted with a request for the resident to be placed on a bowel management regimen to help keep the resident more regular with bowel movements. She said the resident's pain medications could cause constipation. The NHA said staff were educated that if Resident #42 was pacing, she may have increased agitation, increasing her behavior risk. The staff were directed to assist Resident #42 to a less stimulating environment away from other residents and/or take her for a walk. If the resident was agitated, the staff should place her on frequent checks and assess for pain and if she had a bowel movement. The NHA said the goal was to identify any potential triggers before it became a concern. The UM said the care plan was updated to include the risk for unprovoked aggression, the identification of potential triggers, monitor daily for constipation and notify the physician. The activity director (AD) was interviewed on 3/27/24 at 4:59 p.m. She was aware of Resident #42's resident to resident altercations. The AD said when the resident was agitated, her staff would focus on distraction. She said the activity staff was providing one-on-one resident interaction for Resident #42. She said the staff talked to her about things she liked to do. The AD said the resident used to be a receptionist. Staff took her for walks outside and had her hold the facility bunny and cat. She said the staff watched her for signs of agitation such as her tone of voice or changes in her facial expressions and/or would say that she was closed. The AD said social activity groups triggered her sometimes but not always. She said she had not noticed a specific time in day the resident was more triggered the other times in the day.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, interviews and record review, the facility failed to provide an environment as free of accident hazards as possible and ensure residents received adequate supervision and assistance to prevent accidents for two (#52 and #50) of 11 residents reviewed for accident hazards out of 26 sample residents. Specifically, the facility failed to: -Ensure a baseline fall care plan with fall interventions was implemented in a timely manner for Resident #52 who was assessed to be a high risk for falls upon admission; -Implement an appropriate fall intervention for Resident #52 following his fall out of his recliner on 2/20/24; -Implement timely and effective fall interventions for Resident #50; and, -Ensure fall interventions were updated on Resident #50's care plan and staff were consistently implementing the interventions. Findings include I. Facility policy The Fall Management policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 3/27/24 at 4:00 p.m. It read in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. To be effective, a fall reduction program is characterized by four components: -Fall risk evaluation; -Care planning and implementation of interventions; -Ongoing evaluation process quality assurance performance improvement (QAPI); and, -A commitment by caregivers to make it work. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall risk evaluation will be completed within the first 24 hours following admission using the fall risk evaluation. A baseline plan of care will be initiated for residents determined to be at risk. Each resident will be re-evaluated quarterly, annually and when a significant change occurs. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Resident and resident representatives (if applicable) will be invited to all care plan meetings. Please note interventions are to be re-evaluated when a resident falls for efficacy. The following interventions may be considered after identification of root cause: -A physical therapy (PT) evaluation or screen should be considered; -Medications will also be reviewed; -Evaluate physical health status; -Assess the environment and make appropriate changes (like bed in lowest position, night light and placement of furniture); -Offer frequent toileting or follow individualized toileting schedule; -Assess need for a potential room change (as in a room closer to the nursing station); -Positioning devices; -Protective devices; -Restorative nursing; and, -Complete a thorough analysis of the fall including the time of day, location of call, causative factors. Identify whether the interventions were in place at the time of the fall. II. Resident #52 A. Resident status Resident #52, age 81, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included unspecified dementia without behavioral disturbances, severe chronic stage four kidney disease, blindness in both eyes, muscle weakness, unsteadiness on feet and unspecified parkinsonism. According to the 2/16/24 minimum data set (MDS) assessment, Resident #52 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. Resident #52 was dependent upon staff for self-care, functional cognition (planning regular tasks), toileting hygiene, low body dressing, putting on or taking off footwear, transitioning from a sitting position to standing and transfers. Resident #52 required substantial or maximal assistance for rolling over, moving from a sitting to a lying position and transferring from a lying position to sitting on the edge of his bed. B. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/13/24 nursing admission assessment identified Resident #52 had diagnoses of Parkinson's disease and dementia, required extensive assistance from staff for activities of daily living (ADL) and was at risk for falls. -Despite the assessment identifying the resident was at risk for falls, the facility failed to implement a baseline fall care plan upon admission. A fall investigation was completed on 2/20/24 for an unwitnessed fall. Resident #52 was observed lying on the floor by his recline in a supine position (on his back). The resident was unable to recall what he needed before he fell or how he got out of his recliner. Resident #52 had cognitive deficits and was bleeding from his right toenail. His nail was still in place and the area was cleaned and bandaged. The registered nurse (RN) completed an assessment and noted no other injuries and his range of motion was within normal limits to all joints. The RN started neurological checks and his bed was placed in the lowest position with his call light within reach. The immediate actions taken by the nurse were notifying the resident's representative, the physician and the nurse manager. A post-fall assessment was completed on 2/20/24 and documented Resident #52 had an unwitnessed fall. He had his call light within reach and the call light was on. He was identified as a high risk for falls. Resident #52 was sleeping in his recliner and was observed 15 minutes before he fell . The resident could not recall what he was trying to do before he fell . The certified nurse aide (CNA) was in the area but did not witness the fall. The root cause was believed to be cognitive deficits and the intervention implemented was to keep his bed in the lowest position. -However, the facility failed to implement a fall intervention in regards to the resident falling out of his recliner. Resident #52's fall care plan; initiated on 2/21/24 (the day after he fell), documented Resident #52 was at high risk for falls related to confusion, vision or hearing problems, Parkinson's disease, dementia and a history of falling. Interventions were documented as: -Anticipate and meet Resident #52's needs; -Assess the resident's needs for adaptive devices as indicated; -Be sure Resident #52's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; -Encourage rest periods when signs of fatigue are noted; -Encourage Resident #52 to participate in activities that promote exercise and physical activity for strengthening and improve mobility; -Ensure adequate lighting and visual aids are in place on admission assess for communication needs as indicated; -Ensure appropriate position in the wheelchair. Provide assistance with repositioning as indicated; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure that Resident #52 is wearing the appropriate footwear when ambulating or mobilizing in the wheelchair; -Physical therapy to evaluate and treat as ordered and as needed; and -Resident #52 needs prompt response to all requests for assistance. The resident has fluctuating ability to utilize the call light. Provide consistent rounding and offer redirection as indicated. -However, the facility failed to implement any interventions related to preventing another fall for Resident #52 from his recliner. C. Staff interviews The director of nursing (DON), assistant director of nursing (ADON) and clinical consultant (CC) were interviewed on 3/27/24 at 2:08 p.m. The ADON said Resident #52 was admitted as a high risk for falls and the assessment was completed when he was admitted . She said Resident #52 had a fall care plan in place before he fell . She said the baseline care plans were completed at admission during the admission assessment. However, the ADON was unable to provide a baseline care plan for Resident #52. The DON said Resident #52 was attempting to self-transfer and fell out of his recliner on 2/20/24. She said the only injury he sustained was a scrape on his toe. The DON said the interventions put on the resident's care plan did not include an intervention to prevent falls from the recliner. The CC said the RN did not complete the baseline care plan at admission. She said the nurse had to check one of the boxes for the fall care plan to generate and the nurse failed to do that. The CC said it was an educational thing and the facility would ensure the nurses completed the assessments accurately. Licensed practical nurse (LPN) #1 was interviewed on 3/24/24 at 4:45 p.m. LPN #1 said Resident #52 was a fall risk before he fell . She said his fall interventions were frequent checks from staff and to ensure he was positioned in the middle of his bed because sometimes he had rolled toward the edge of the bed. She said Resident #52 had never tried to transfer himself before his fall on 2/20/24. She said the resident was good at using his call light and waiting for assistance. LPN #1 did not mention any interventions for Resident #52 to prevent falls while he was in his recliner. 40467 III. Resident #50 A. Resident status Resident #50, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dementia, history of falls, repeated falls, fracture of the right femur, unsteadiness on feet, muscle weakness, difficulty walking and cognitive communication deficit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 12/30/23 MDS assessment, Resident #50 had severe cognitive impairment with a BIMS score of four out of 15. The resident did not have rejection of care behaviors. The resident's functional ability at admission was identified as limited range of motion on one side of her lower extremity, dependent on staff for toileting, dressing including putting on and taking off footwear. The resident required substantial assistance during bed to chair transfers. B. Observations Continuous observations were conducted on 3/24/24 from 9:32 a.m to 9:59 a.m., 11:39 a.m. to 12:40 p.m. and 2:50 p.m. to 4:10 p.m. Resident #50 was observed in her wheelchair in the common area of the memory care unit during all of the observations. -The resident's wheelchair did not have anti-tip brakes attached on the back of her wheelchair to prevent the wheelchair from rolling backwards (see 3/11/24 interdisciplinary team (IDT) risk management note and interviews below). -At 2:55 p.m. the activity assistant (AA) attempted a reading activity with Resident #50 and two other residents. As the AA moved one of the residents closer to her, Resident #50 placed her hands on her armrests and pushed herself up to a partial standing position and then sat back down in her wheelchair. Continuous observations were conducted on 3/25/24 from 11:50 a.m. to 12:42 p.m. and 2:00 p.m. to 3:44 p. m. -The resident did not have anti-tip brakes attached to the back of her wheelchair. -At 2:07 p.m., Resident #50 sat still in her wheelchair as she listened to a harpist playing in the common area. -At 2:12 p.m., the harpist finished playing and Resident #50 was leaning to her right side. Her body jerked up slightly and then she leaned to the right again. The resident was not offered to lay down when the music was over despite the resident displaying signs of being tired. -At 2:19 p.m., Resident #50 started leaning and reaching forward and as she proceeded to lift herself up from the seat of her wheelchair. The right wheel of the resident's wheelchair rolled backwards as she sat back down. A CNA, who was the only staff member in the vicinity, was in the kitchenette and did not notice the resident's wheelchair roll backwards. A resident next to Resident #50 asked her if she needed help and Resident #50 responded yes. The other resident started to lift himself out of his wheelchair to help her. The CNA saw the male resident and asked him what he needed. The resident motioned to Resident #50. The CNA asked Resident #50 what she needed and Resident #50 reached her arms forward. The CNA unlocked the resident's left wheelchair brake and told her she could go forward with her feet. The resident proceeded to use her feet to mobilize herself in her wheelchair in the common area. -At 2:28 p.m. Resident #50 was offered a snack pack of mini muffins. The resident ate the muffins in the hall and common area, dropping one and attempted to pick it up by reaching down to the floor and placing another muffin on the floor in front of her as she sat in her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation was conducted on 3/26/24 from 9:04 a.m. to 9:20 a.m. The resident received a massage and was assisted to exercise. -Resident #50 did not have anti-tip brakes on her wheelchair. A continuous observation was conducted on 3/26/24 from 12:20 p.m. to 12:47 p.m. -The resident did not have anti-tip brakes on her wheelchair. On 3/27/24 at 3:38 p.m., Resident #50 was observed in her wheelchair with the DON, the CC, the unit manager (UM) and the ADON. -Resident #50 did not have anti-tip brakes on her wheelchair. The UM said Resident #50 was in the wrong wheelchair. The CC said all the wheelchairs, including Resident #50's, would be labeled with the residents' name to ensure the residents were placed in their correct wheelchairs. The CC said the lack of the anti-tip brakes probably contributed to the resident's two falls on 3/24/24 because the resident did not have the right equipment that she was identified to need. C. Record review The 10/17/23 fall risk evaluation identified Resident #50 was a high risk for falls. The fall risk evaluation read the resident was at high risk for falls related to a history of falls, poor vision and had medications and diagnoses that could contribute to falls. The 10/17/23 progress notes read Resident #50 was admitted to the facility on [DATE] for physical therapy (PT) and occupational therapy (OT) following surgery for a right hip internal fixation. The notes identified the resident suffered a fracture to right hip from a fall prior to her admission, she had impaired vision related to macular degeneration and was at risk for falls. The 10/18/23 skilled nursing note read Resident #50 had weakness and an unsteady gait requiring supervision. The fall care plan, initiated on 10/18/23, read Resident #50 was a high risk for falls due to history of falls resulting in a femur fracture. The 10/18/23 interventions included PT to evaluate and treat as ordered or as needed. The review of Resident #50's electronic medical record (EMR) identified Resident #50 had eight falls between 11/15/23 and 3/24/24. 1. Fall #1 The 11/8/23 nursing progress note read the resident had increased confusion and tried to get out of her chair (wheelchair). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/15/23 at 8:17 a.m. nursing progress note read Resident #50 was observed by a CNA on the floor next to her bed in a sitting position with legs out in front of her. The resident was upset and scared. An abrasion on her back was identified when she was getting dressed. The 11/17/23 interdisciplinary team (IDT) note read Resident #50 had an unwitnessed fall with no signs of obvious injuries. Resident #50 had poor safety awareness and attempted self transfer. The staff was verbally educated to frequently check on Resident #50 to alleviate risk of falls. -The IDT note did not identify the abrasion on the resident's back after the resident's fall, The fall care plan, initiated on 10/18/2023 and revised on 11/21/2023 (six days after the fall on 11/15/23), directed staff to anticipate and meet the resident's needs, complete frequent checks to prevent falls, assess the resident's need for adaptive devices as indicated and ensure the resident wearing appropriate footwear when mobilizing in her wheelchair. 2. Fall #2 A 12/3/23 nursing note read Resident #50 was observed at the table in the dining room repeatedly standing up from her wheelchair by herself. The resident lacked safety awareness, her wheelchair wheels were not locked, and her foot pedals were down in the front and her feet were crossed while standing. Education was provided and the resident was reminded to ask for staff assistance but she often seemed to forget. A 12/4/23 late entry incident note read the nurse entered Resident #50's room after she heard a loud noise and Resident #50 yelling. The resident was found sitting on the floor by her bed and her recliner. The blankets were slightly pulled off her bed on the same side of the bed where she was found. The resident was not in acute distress but reported pain on the left side of her ribs under her arm. There was no bruising or skin injury observed at the time of the fall. The resident said she was trying to move from the bed to the chair and slipped. The intervention was identified as a low bed would be placed in her room and the resident was encouraged to wear non-skid socks at night to reduce future fall risk. The 12/4/23 incident report read the 12/4/23 fall at 7:00 a.m. was unwitnessed. Predisposing factors included poor gait and balance, a high risk for falls and poor safety awareness, ambulating without assistance and had a recent room change. -According to the incident report, the resident's bed was not in its lowest position at the time of her fall. The 12/6/23 IDT risk management note read Resident #50 had an unwitnessed fall on 12/4/23. The resident had poor safety awareness and was attempting to self transfer from bed to chair. The resident reported pain to her left ribs. There was no bruising or injury noted. The intervention was identified as a PT referral, frequent checks and rounding by staff and anticipate Resident #50's needs. -The review of Resident #50's fall care plan did not identify new fall interventions that were put into place after the resident tried to ambulate from the bed to her chair and fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Fall #3 The 12/9/23 nursing progress note read Resident #50 was trying to get up out of her wheelchair without assistance. She would get mad when staff told her it was unsafe and she had to wait for someone to help. She continued to try to get up from her wheelchair throughout the evening until she settled in bed. Her call light was placed within reach. The 12/15/23 nursing progress note read Resident #50 was sitting in the dining room recliner and tried to get up from it. She was told she had to wait for staff to help her get into her wheelchair. According to the note, the resident became upset and started to kick and swing at the staff. The resident was told it was unsafe for her to get up by herself and she proceeded to continue to try to swing at staff and said she did not need assistance. The resident calmed after staff sat with her for an hour. The 12/25/23 at 4:00 a.m incident note read Resident #50 was found scooting on the floor in a sitting position by her door entry in her room. The resident said her brief was soiled. There were no injuries noted. The intervention was staff to attempt to check and change her first for a wet brief during staff rounds. The 12/25/23 incident report read the resident was identified as high risk for falls, incontinent, poor safety awareness and gait imbalance. The 12/26/23 IDT risk management note read Resident #50 had an unwitnessed fall on 12/25/23. The root cause of the fall was poor safety awareness. The resident said she was scooting around on the floor and had a soiled brief. The intervention noted on the IDT note was to start PT again and staff to check on her first when doing rounds. -The review of the care plan did not identify new fall interventions were put into place after the resident was incontinent and found scooting on the floor in her room on 12/25/23. The 1/22/24 care plan for wandering read Resident #50 wandered related to her dementia and impaired safety awareness. According to the care plan, the resident was easily redirected. The care plan directed staff to assess the resident for a fall risk. 4. Fall #4 The 1/7/24 skilled nursing note read Resident #50 was observed wandering around the unit for most of the shift. She frequently entered others' rooms. She attempted to open back doors several times and got her wheelchair stuck on furniture and on other resident's wheelchairs. She was tearful at times and did not respond well to redirection. The 1/17/23 fall risk evaluation identified Resident #50 was a high risk for falls. The fall risk evaluation read the resident remained at a high risk for falls to include contributing factors of blood pressure changes between lying and standing. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/10/24 incident report read the resident had an unwitnessed fall on 3/10/24 at 7:55 p.m. The factors to the fall included the resident was ambulating without assistance, was wandering and was wearing improper footwear. The 3/11/2024 IDT risk management note read Resident #50 had an unwitnessed fall on 3/10/24. The root cause was poor safety awareness and she tended to try and stand from her wheelchair when she became stuck somewhere. There were no injuries. The IDT note read Resident #50 was very restless. The CNAs had placed Resident #50 in her bed but in fear of the resident falling out of bed, the CNAs transferred her back to her wheelchair. The resident had been wandering into another resident's room. She got stuck between the bed and the recliner. When the resident stood up, the wheelchair rolled out from behind her. -According to the note, anti-tip/roll back locks/brakes would be placed on her wheelchair, however, observations revealed the resident did not have anti-tip/roll back devices on her wheelchair (see observations above). -The fall care plan did not identify new interventions were placed on the care plan such as placing anti-tip/roll back locks/brakes to her wheelchair and monitor. 7. Fall #7 The 3/18/24 fall risk assessment identified the resident was at a high risk for falls related to history of falls, periods of confusion, was wheelchair bound and required assistance with toileting. The 3/24/24 nursing progress note read the nurse was informed of the resident's fall at 2:47 a.m. Resident #50 was observed sitting on the floor beside her bed. There were no injuries and the resident was assisted back to bed. The 3/24/24 post fall assessment report documented the resident was not wearing footwear at the time of the fall. The 3/24/24 at 4:48 p.m. IDT risk management note read Resident #50 had an unwitnessed fall on 3/24/24. The resident was found sitting on the floor in her bedroom with the bed not in the lowest position. The root cause of the fall was poor safety awareness and the resident was impulsive. According to the note, the resident would often try to stand up or transfer without assistance. The resident was not injured. The intervention was to conduct a facility wide staff education on ensuring beds are in lowest position and call lights are within reach every time staff left a room. -According to the report, the resident's bed was not in its lowest position at the time of her fall. 8. Fall #8 The 3/20/24 nursing progress note read Resident #50 received a new order for the medication Celecoxib 100 mg BID. According to the note, the resident had the medication previously and it was discontinued. The note read after the discontinued medication, the resident became tearful and complained of pain to her left inner groin and had trouble standing related to pain. The first dose of the medication was given without adverse reactions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/23/2024 nursing progress note read the resident had no adverse reactions to the new medication Celecoxib. The resident had been more active while in her wheelchair and was less sleepy and tearful. According to the note, the resident stood better during transfers and did not complain of discomfort or pointing to her left hip and inner groin. The 3/24/24 nursing note read Resident #50 had no adverse reactions noted to the new medication Celecoxib. The resident had an unwitnessed fall and would continue to be monitored. A 3/24/2024 nursing progress note identified Resident #50 had a second fall on 3/24/24 at 7:20 p.m. The note read the nurse was called to the unit to assess the resident after a fall. The resident did not have discomfort on injuries. The 3/24/24 incident report identified the resident had another unwitnessed fall in another resident's room. The resident was found on the floor in another resident's room on 3/24/23 at 7:20 p.m. The resident was found between her wheelchair and a recliner. According to the report, the resident was possibly self transferring from her wheelchair to the recliner when she fell . The resident did not have injuries as a result of her fall. Predisposing factors included poor lighting, impaired memory and history of falls in the past 30 days. The 3/25/24 IDT risk management note read Resident #50 had an unwitnessed fall. She had poor safety awareness and was impulsive. She recently had pain medication discontinued and was noted to be restless, tearful, and pacing. The resident had had repeat falls since the discontinuation of her pain medication. She was found on the floor in another resident's room up against a recliner. She attempted to self transfer from her wheelchair to the recliner and fell . -The IDT note did not identify if the intervention of anti-tip brakes on her wheelchair were in place. The intervention after the 3/24/24 fall was to place the resident back on Celecoxib as 3/25/24 for pain management. The March 2024 CPO read to give Resident #50 Celecoxib (Celebrex) oral capsule 100 (mg by mouth two times a day for pain. The order read it was active as of 3/25/24. -However, according to nursing [TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48412 Based on observations, record review and interviews the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and two of two kitchenettes. Specifically, the facility failed to ensure: -Dented canned foods were not stored to be served to residents and food items were labeled with use-by dates; -Kitchen staff appropriately cleaned thermometers before temperatures were obtained from ready-to-eat foods; -Spare thermometers were kept in each refrigerator and freezer in case the digital thermometer went out and thermometers in the refrigerators and freezers were not broken; -Kitchen refrigerators were held at the appropriate temperature; and, -Cold foods were held at 41 degrees Fahrenheit (F) or below before serving residents. Findings include: I. Pantry items and food storage A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved 4/2/24 from: https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, revealed in pertinent part, Products that are held by the permit holder for credit, redemption or return to the distributor, such as damaged, spoiled or recalled products shall be segregated and held in designated areas that are separated from food, equipment, utensils, linens, single-service and single-use articles. The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 4/2/24 from: https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, revealed in pertinent part, A date marking system that meets the criteria stated in (2) of this section may include: Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; or Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the Department upon request. B. Facility policy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Food Wholesomeness: Procurement, Storage, Preparation and Service Sanitary Conditions policy, revised January 2024, was provided by the nursing home administrator (NHA) on 3/27/24 at 4:00 p.m. read in pertinent: Foods not in original containers are labeled and dated with an opening date and suggested to have a use-by date. C. Observations On 3/24/24 at 9:28 a.m. during the initial kitchen tour, a large can of potatoes was observed with a large dent in the can on the shelf in the pantry to be used in a meal. Large plastic containers were observed with dates that were not specified as being an opening date or a use-by date. The large plastic containers were not labeled as to what the item was inside. There was a prepared container of food in the walk-in cooler that appeared to be tomato based that was not labeled or dated. D. Staff interviews The dietary manager (DM) was interviewed on 3/27/24 at 10:49 a.m. She said she was unaware there was a defective can in the pantry. She said the kitchen staff did not use defective cans and would remove the canned potatoes. The DM said the dates were the dates when the items were opened. She said she saw the issue with just writing a month and day because some of the days were interpreted to be years. She said she was going to address the labels and ensure they said when they were opened and would display the entire date. II. Improper cleaning of food thermometer A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved 4/2/24 from: https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view, revealed in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. Equipment food-contact surfaces and utensils shall be cleaned before using or storing a food temperature measuring devices. B. Lunch observations on 3/26/24 at 11:45 a.m. At 12:10 p.m. a resident requested soup for lunch. The dietary aide (DA) was observed removing the soup from the microwave. She took an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the soup and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:25 p.m. a resident requested a side of soup with his lunch. The DA was observed removing the soup from the microwave. She took an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the soup and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. At 12:30 p.m. another resident requested soup for lunch. The DA was observed removing the soup from the microwave. She took an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the soup and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. At 12:31 p.m. the DA removed a personal-sized mini pizza from the oven to check the temperature before serving it to a resident. The DA was observed removing the pizza from the microwave. She took an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the pizza and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. The pizza was returned to the oven because it was not the correct temperature. At 12:44 p.m. the DA removed the pizza from the oven and was observed taking an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the pizza and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. The pizza was returned to the oven for still being at the incorrect temperature. At 12:47 p.m. the DA removed the pizza from the oven and was observed taking an alcohol wipe out to clean the thermometer before she obtained the temperature. She poked the thermometer through the middle of the alcohol wipe, without fully opening the wipe. She then ran the alcohol wipe and its packaging up and down the thermometer probe. She obtained the temperature of the pizza and cleaned the thermometer probe by poking a hole through another alcohol wipe and moving it up and down the thermometer probe. The pizza was served to the resident. C. Staff interviews The DM was interviewed on 3/27/24 at 10:49 a.m. She demonstrated how the kitchen staff were to clean the food thermometers. She took an alcohol wipe and removed the paper packaging. She then took just the wipe, folded it around the thermometer probe and moved the wipe along the probe. She said she was unaware the DA poked through the packaging of the wipe to sanitize the thermometer probe. The DM said the way the DA cleaned the thermometer was not sufficient because the alcohol wipe needed to be removed from its packaging to clean the probe. She said she was going to provide education to all of the kitchen staff and ensure they cleaned the thermometer correctly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	III. Refrigerator and freezer thermometers and temperatures A. Observations on 3/24/24 At 9:28 a.m. the silver side-by-side freezer had a digital thermometer but there was not an internal thermometer as a backup in the freezer. The walk-in cooler had a digital thermometer that did not show the temperature, the screen was black. A spare thermometer could not be located inside the refrigerator or freezer located within the walk-in cooler. At 9:40 a.m. the refrigerator and freezer in the south hall's kitchenette were observed. The thermometer in the refrigerator read 50 degrees Fahrenheit (F). The thermometer in the freezer displayed a red line that was not solid which indicated that the thermometer was broken. There was not a digital thermometer for this refrigerator and freezer. At 9:50 a.m. the refrigerator and freezer in north hall's kitchenette were observed. The spare thermometers in the refrigerator and freezer displayed a red line that was not solid which indicated the thermometers were broken. B. Staff interviews The DM was interviewed on 3/27/24 at 10:49 a.m. She said the kitchen staff were responsible for the refrigerators and freezers but that nursing staff assisted with checking on foods stored in the unit refrigerators. She said she was unaware some of the thermometers were missing and some were broken. She said she was not sure why the walk-in cooler digital thermometer did not display the temperature. She said she had spare thermometers and would replace them and worked with the kitchen staff to ensure temperatures were obtained and monitored for each refrigerator and freezer at the facility. IV. Cold foods A. Professional reference The Colorado Retail Food Regulations, effective 1/1/19 and retrieved 4/2/24 from https://cdphe.colorado.gov/environment/food-regulations read in pertinent part, Except during preparation, cooking, or cooling, time and temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less. Equipment for cooling and heating food, and holding cold and hot food, shall be sufficient in number and capacity to provide food temperatures as specified. The FDA (Food and Drug Administration) food code reviewed on 3/27/23 and retrieved 4/2/24 from https://www.fda.gov/food/fda-food-code/food-code-2022 read in pertinent part, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone (41 degrees to 135 degrees F) too long. B. Facility policy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Food Wholesomeness: Procurement, Storage, Preparation and Service Sanitary Conditions policy, revised January 2024, was provided by the nursing home administrator (NHA) on 3/27/24 at 4:00 p.m. read in pertinent: Cold foods are kept between 34 to 41 degrees Fahrenheit (F) before serving; and Foods not in original containers are labeled and dated with an opening date and suggested to have a use-by date. C. Observations on 3/26/24 At 11:45 a.m. the DM and DA were preparing to start serving lunch. There were individual bowls of fresh mixed fruit sitting on the counter but were not on ice. At 12:10 p.m. the meal cart for [NAME] Hall was completed. The DM started plating for the next meal cart. The mixed fruit was not on ice. At 12:23 p.m. the meal cart for South Hall was completed. The DM started plating for the next meal cart. The mixed fruit was not on ice. At 12:38 p.m. the final meal cart for North Hall was completed. The mixed fruit was not on ice. At 12:48 p.m. after all the residents were served, the fresh fruit was 63.6 degrees F. D. Staff interviews The DM was interviewed on 3/27/24 at 10:49 a.m. She said she had been at the facility for about a year and the temperature of the meals had been a continuous issue since she started. She said the lettuce and tomato that was used as a topping was on ice and she did not think about the fruit. The DM did not obtain the temperature of the fruit at the beginning of lunch and did not check the temperature after lunch was served. She said she was going to make sure it did not happen again.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on observations and interviews, the facility failed to maintain the emergency response equipment in safe operating condition for one of two emergency response carts. Specifically, the facility failed to: -Ensure the oxygen cylinder on the south emergency response cart was secured on the emergency cart; -Ensure nursing staff were trained to use portable oxygen; and, -Ensure expired medical supplies on the south unit emergency cart were removed from the care area. Findings include: I. Oxygen cylinder failures A. Facility policy The Oxygen policy, dated 2/29/24, was received 3/26/24 at 12:26 p.m. by the director of nursing (DON). The policy read in pertinent part, Secure each tank individually, by a chain, on a cart or on a stand. B. Observations and interviews On 3/25/24 at 11:57 a.m., the emergency response cart was observed and inspected with registered nurse (RN) #1. The emergency response cart was designed to secure a type E (25.5 inches in length) oxygen cylinder. -The emergency cart was observed with a smaller size M (16.5 inches in length) oxygen cylinder that hung loosely by the oxygen regulator and swung back and forth freely when touched. -The oxygen cylinder was not secured to the emergency equipment cart. RN #1 said the cylinder should be secured but did not know if a size E oxygen cylinder was available. RN #1 said she was unable to verify the oxygen level in the cylinder because she was not familiar with the cylinder, had not been trained on the cylinder and was unsure how to turn on the oxygen in the cylinder. She observed the oxygen flow regulator and said the indicator read empty. RN #1 said the oxygen cylinder was not correctly secured to the emergency cart and she did not know if a replacement oxygen cylinder that could be secured on the equipment cart was available. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 reviewed the daily checklist record for the emergency cart and said the cart had been checked daily in March 2024. RN #1 said the daily checklist did not include the requirement to inspect and check the oxygen on the cart. She said if she needed emergency oxygen, she would use an oxygen supply from a resident room. She said if an emergency occurred away from a resident room and she needed the oxygen cylinder, she would ask a staff member to assist her with the oxygen. RN #1 said the city emergency response teams usually arrived in about ten minutes and they would assist with oxygen administration. RN #1 said it was the responsibility of the night shift nurse to inspect and verify the emergency equipment care was inspected and ready for use. On 3/26/24 at 9:05 a.m. and 11:45 a.m., the oxygen cylinder was observed again. The smaller oxygen cylinder continued to be unsecured to the emergency response cart and hung on the cart from the oxygen regulator. II. Emergency equipment failure A. Professional reference According to [NAME], [NAME], (2022). Crash cart preparedness and failure to rescue a case study review, retrieved on 3/29/24 from https://www.researchgate.net/publication/360555126_Crash_cart_preparedness_and_Failure_to_rescue_A_case_study_review,, A crash cart is a mobile cabinet on wheels that contains equipment required for emergency cardio-pulmonary resuscitation. The carts are individualized and conveniently located throughout healthcare facilities for rapid access in the event of an emergency. A crash cart is typically located in the setting of an unexpected medical emergency. This could include severe allergic reaction, cardiac or respiratory arrest, and conditions with an unexpected sudden deterioration of vital signs. This would require equipment located on the card cart which would be used by a credentialed life support provider. While crash carts vary depending on location, the fundamentals for the crash cart will contain similar equipment. Although the organization of requirements for a crash cart is not generic, there is a fundamental standard which provides effortless access to emergency medical equipment. Note that all these organizational points are checked, dated, and signed by the staff member who performed the daily routine inventory and inspection. Side or rear -The oxygen cylinder should be secure on the side of the cart, with a full oxygen pressure level. Recommended equipment and medications -Organization and location specific. Recommended maintenance -Check expiration dates on equipment and medications per organization policy and replace as required. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Schedule inventory check -The purpose of a crash cart inventory is to organize a schedule of when to check for expiration dates of equipment and supplies. -Check that equipment is operating as required in the event of an emergency. In addition to recording who performed the inventory checks, with dates, times, and signatures. An alarming situation for the healthcare personnel requiring a crash cart is to find unusable equipment or expired medications in an emergency. Ensuring that an up-to-date, accurate, and truthful inventory record can avoid potential patient safety situations such as absence of equipment, equipment failure, expired or missing medication, and empty oxygen cylinders. The patient safety risk incident failure to rescue is perpetrated by healthcare professionals when they do not check cart accurately. Failure to follow standard or policy for checking equipment compromises patient safety and creates potential to harm patients. B. Facility Policy The emergency equipment policy was requested on 3/25/24, however, a policy was not provided by the end of the survey. C. Observations and interviews On 3/25/24 at 11:57 a.m., a plastic pencil box labeled cor (emergency) cart was observed with RN #1 in the top drawer of the emergency response cart. The pencil box contained a glucometer designated for emergency use. The pencil box included a glucometer, lancets, loose cotton balls, alcohol wipes and glucometer test strips. RN #1 observed the glucometer test strip container, labeled assurance platinum test strips 50 count, expired 9/17/21 and included four test strips. RN #1 said if an expired test strip was used, an incorrect blood sugar level could be the result. RN #1 immediately removed the expired test strips from the emergency equipment cart. RN #1 said the night shift nurse was responsible for checking the supplies and should have removed the expired glucometer test strips. IV. DON observation and interviews On 3/25/24 at 12:25 p.m., the DON observed the emergency response cart. She said the oxygen cylinder was not secured safely to the emergency response cart and the cylinder should not hang or swing by the regulator valve. She said the facility would replace the small cylinder with a larger cylinder for secure storage. -Despite the DON indicating the facility would replace the oxygen cylinder with a larger cylinder on 3/25/24, the smaller oxygen cylinder continued to be unsecured to the emergency response cart and hung on the cart from the oxygen regulator (see observations above). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the glucometer should not have been stored in the emergency response cart. She observed several medical supplies such as various sizes of oral airways that were not included on the inventory list but were stored in the equipment drawers. The DON said she would provide mandatory education on the emergency response cart storage and oxygen use with nursing staff. The DON was interviewed again on 3/26/24 at 12:35 p.m. The DON said the facility did not have a policy for the emergency response cart. She provided a copy of a blank, undated, emergency response cart checklist. The DON said the checklist did not include a check for a glucometer or the oxygen cylinder. She said the glucometer should not have been stored on the emergency response cart.