Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065378	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Post Acute	2311 E Bridge St Brighton, CO 80601

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 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.

47151

Based on observations, record review and interviews, the facility failed to ensure residents were treated with respect and dignity by providing care in a dignified, respectful and individualized manner for one (#26) of four residents reviewed out of 36 sample residents and on one of three units.

Specifically, the facility failed to:

-Ensure residents who were prescribed a puree diet received the menu options as listed on the main menu or according to their preference and prescribed diet order; and,

-Provide residents on the Aspen unit with non-disposable beverage cups at meals.

Findings include:

I. Failed to ensure residents who were prescribed a puree diet, received the menu options as listed on the main menu or according to their preference and prescribed diet order

A. Facility policy and procedure

The Resident Food Preferences policy, revised July 2017, was provided by the nursing home administrator (NHA) on 3/26/25 at 11:32 a.m. It read in pertinent part, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and meal times. Nursing staff will document the resident's food and eating preferences in the care plan.

B. Resident representative interview

Resident #26's representative was interviewed on 3/24/25 at 2:42 p.m. The resident representative said she could never find the puree diet menu. The resident representative said she had tried sitting down with Resident #26 and selecting things from the menu he would like, but when Resident #26 received his tray, he did not receive the menu items he had ordered. The resident's representative said she never knew what food items were on Resident #26's plate, so she would have the resident guess what he was eating.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations and test tray During a continuous observation on 3/25/25, beginning at 11:10 a.m. and ending at 12:37 p.m., the following was observed during the meal preparation and service in the main kitchen: The posted menu was beef tostada with shredded lettuce and tomato and fruit crisp. At 11:12 a.m. cook (CK) #1 assembled a meal plate with mashed potatoes and puree meat and placed the meal in the serving window. The resident's meal ticket documented the resident was on a mechanical soft diet with puree meat and' cheeseburger' was written on the ticket. Restorative aide (RA) #1 looked at the meal and told CK #1 the resident ordered a cheeseburger and walked away from the serving window. At 11:13 a.m. RA #1 picked up the meal plate from the serving window and delivered it to the resident without a cheeseburger on the plate. At 12:35 p.m. a puree test tray was provided. The puree texture test tray consisted of puree beef, mashed potatoes, pureed peas and carrots and chocolate pudding for dessert. -The puree test tray did not include puree fruit crisp or puree noodles as documented on the diet modification spreadsheet. D. Record review The facility menus and puree daily standards were provided by the NHA on 3/24/25 at 3:24 p.m. The puree daily standards documented high quality leftovers from the previous meal/day would be saved and pureed to proper consistency following International Dysphagia Diet Standardization initiative IDDSI) standard for the next meal period. Lunch was pureed and served for dinner and dinner for lunch (the following day). Breakfast would be pureed fresh daily and the puree items were tossed after each meal period. The menu diet modification spreadsheet was provided by the dietary director (DD) on 3/26/25 at 5:00 p.m. The spreadsheet documented that for the lunch meal served on 3/25/25 the puree lunch included puree beef and noodles with sauce, and a puree fruit crisp and puree green chili stew. -However, the residents were served puree beef, mashed potatoes, puree peas and carrots and chocolate pudding. E. Staff interviews RA #1 was interviewed on 3/25/25 at 11:45 a.m. RA #1 said she did not know why the resident did not receive a cheeseburger with his meal. She said she thought maybe it was because the resident would also have puree bread with puree meat (of his cheeseburger). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DD and the NHA were interviewed together on 3/26/25 at 12:00 p.m. The DD said the staff pureed leftover food served at the previous meal for residents prescribed a puree diet. The DD said the test tray consisted of roast beef, mashed potato and peas and carrots. The DD said he did talk to the dietary staff after lunch on 3/25/25 and educated the staff to serve the resident a puree burger if that was the resident's preference. The DD said the resident had a mechanical soft diet order with an additional order for puree texture meat. The NHA said he thought the dietary staff pureed food from the previous meal so the staff could have the puree items ready to go ahead of time. The NHA said he had not previously heard any concerns about the puree food items. 20287 II. Failed to provide residents on the Aspen unit with non-disposable beverage cups at meals. A. Observations On 3/25/25 at 11:30 a.m. the residents in the Aspen women's secured unit were served their meals. The residents were served their milk, punch and coffee in paper and styrofoam cups instead of plastic cups. On 3/25/25 at 5:00 p.m. the residents on the Aspen women's secured unit were served their meals. The residents were served their beverages in paper and styrofoam cups instead of plastic cups. On 3/26/25 at 11:30 a.m. the residents in the Aspen women's secured unit were served their noon meals. The residents were again served all of their beverages in paper and styrofoam cups instead of plastic cups. B. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 3/25/25 at 12:00 p.m. CNA #10 said the residents on the women's secured unit always received both paper and styrofoam cups for their beverages. She said it had something to do with the kitchen, however she said she was not sure of the exact reason. Licensed practical nurse (LPN) #2 was interviewed on 3/26/25 at approximately 12:00 p.m. LPN #2 said the kitchen always sent paper cups for the residents' beverages on the women's secured unit. She said she was not sure of the reason. She said the men's secured unit received washable non-disposable plastic cups.

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 50219

Based on observations, record review and interviews, the facility failed to ensure four (#59, #39, #97 and #42) of nine residents out of 36 sample residents were kept free from abuse.

Specifically, the facility failed to:

-Protect Resident #59 and Resident #39 from sexual abuse by Resident #62;

-Protect Resident #97 and Resident #34 from physical abuse by each other; and,

-Protect Resident #42 from physical abuse by Resident #58.

Findings include:

I. Facility policy and procedure

The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 3/23/25 at 12:41 p.m. It read in pertinent part, Residents have the right to be free from abuse.

The facility will implement measures to address factors that may lead to abusive situations.

The facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The facility will investigate and report any allegations within timeframes required by federal requirements.

II. Incident of sexual abuse of Resident #59 and Resident #39 by Resident #62 on 3/21/25

A. Facility investigation

The facility's incident investigation, undated, was provided by the NHA on 3/24/25 at 4:21 p.m. The investigation included a statement from certified nurse aide (CNA) #4, which revealed on 3/21/25 between 1:30 a.m. and 2:00 a.m., CNA #4 observed Resident #62 as he was halfway into Resident #39 and Resident #59's shared room. Resident #62 had exposed his genitals and was masturbating in the room. CNA #4 took Resident #62 back to his room and told him he could not be in other residents' rooms.

Resident #39 was interviewed by the NHA on 3/21/25. Resident #39 said she did not have any incidents of abuse to report. Resident #39 said she felt safe in the facility. Resident #39 said she did not notice any disturbances during her sleep. Resident #39 said there was nothing else she wanted to share.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #59 was interviewed by the NHA on 3/21/25. Resident #59 said she did not have any incidents of abuse to report. Resident #59 said she felt safe in the facility. Resident #59 said she did not notice any disturbances during her sleep. Resident #59 said there was nothing else she wanted to share. The investigation included a secure neighborhood placement evaluation, dated 3/21/25, for Resident #62. -The documents did not include a formal abuse investigation, interviews with any other residents in the vicinity, an interview with Resident #62 or any other interviews with staff members. B. Resident #62 (assailant) 1. Resident status Resident #62, age 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included sexual dysfunction and major depressive disorder. The 12/17/24 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. The resident needed setup or cleanup assistance for most activities of daily living (ADL). The MDS assessment documented the resident did not have physical or verbal behaviors directed toward others or other behavioral symptoms not directed toward others. 2. Record review The behavioral care plan, initiated 7/17/2020 and revised 4/14/23, revealed Resident #62 made verbally explicit comments and suggestions toward staff, masturbated in front of staff, asked female staff members if he could touch them or if the staff could touch him in a sexually inappropriate way. Pertinent interventions included explaining or reinforcing why his behavior was inappropriate or unacceptable, administering medications as ordered, educating staff on the importance of respecting Resident #62's wishes and emphasizing sexual outlet was a normal function, monitoring behavioral episodes and attempting to determine an underlying cause, redirecting any inappropriate public exposure and intervening as necessary to protect the rights and safety of others. The activities care plan, revised 3/18/25, revealed Resident #62 was part of an activities work reward program in which he passed out news bulletins on the South neighborhood as it gave him purpose and satisfaction to speak with his peers and staff daily. Pertinent interventions included ensuring Resident #62 had the appropriate leisure material in order to be set up for success and having staff remind and encourage Resident #62 to participate in the work reward program. The antipsychotic medication care plan, revised 12/30/24, revealed Resident #62 required an antipsychotic medication as evidenced by inappropriate sexual behavior, delusions and hallucinations. Pertinent interventions included administering antipsychotic medications as ordered, observing Resident #62's mood and response to the medication and observing and recording the effectiveness of the drug treatment as indicated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 1/16/25 at 9:56 p.m., revealed Resident #62 was being inappropriate in his room and masturbating during medication pass. -However, the incident was not documented in the behavior tracking software or in the resident's treatment administration records (TAR). A progress note, dated 1/29/25 at 9:54 p.m., revealed Resident #62 was asking an unidentified nurse and CNA to come into his room. When the nursing staff members responded and asked Resident #62 what he needed, he did not respond. When the nurse was in Resident #62's room assisting his roommate, Resident #62 began looking at the nurse inappropriately and grunting. When the nurse exited the room, Resident #62 told her he loved her. -However, the incident was not documented in the behavior tracking software or in the TAR. A progress note, dated 3/21/25 at 12:39 p.m., revealed an unidentified CNA witnessed Resident #62 masturbating in another resident's room. The other residents slept through the situation and did not wake up. The CNA relocated Resident #62 away from the room and told the resident he could not perform those actions in others' rooms. The director of nursing (DON) spoke with Resident #62 and gave him choices to ensure his safety and the safety of others, and the resident agreed to relocate the resident to the all-male secured unit. The nursing staff were to continue to monitor Resident #62 for hypersexual behaviors. -However, the incident was not documented in the behavior tracking software or in the TAR. A quarterly interdisciplinary team (IDT) conference, initiated 3/20/25 at 12:21 p.m. and finalized 3/23/25 at 9:09 p.m., revealed Resident #62 was independent in his activities of choice. Resident #62 participated in the work therapy program by passing out the daily bulletin. Resident #62 enjoyed watching television (TV), visiting with his peers, and going out for scheduled smoke breaks. Resident #62 was re-educated on places in which it was appropriate to masturbate. Resident #62 was re-educated on not going into other residents' rooms. An IDT note, dated 3/25/25 at 9:30 a.m., revealed that on 3/21/25 at 1:30 a.m. Resident #62 was observed by a CNA masturbating in the doorway of Resident #39 and Resident #59's room. When confronted, Resident #62 said he did not know what they were talking about. Interventions implemented included moving Resident #62 back to the all-male secured unit. Risk factors included Resident #62's history of sexually inappropriate behavior and mental illnesses. A change in condition note, dated 3/26/25 at 3:33 p.m., revealed Resident #62 had a change in condition due to behavioral symptoms. The note documented the facility staff said Resident #62's behaviors were still present with masturbation in public view. No new interventions or orders were documented. Behavior tracking through the facility's behavior tracking software was reviewed from 9/24/24 through 3/25/25 and revealed the following: On 11/14/24 at 11:40 a.m. Resident #62 asked a CNA to wash his private area while she was assisting him with his shower and Resident #62 told the CNA he could see down her shirt as she was assisting him with putting on his socks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/19/25 at 8:08 p.m. a CNA reported to the nurse that Resident #62 was masturbating and saying to her I know you're over there baby, come on over here repeatedly. The nurse educated Resident #62 that he could masturbate in his room privately but it was unacceptable to ask any staff members to help him. -However, the 1/19/25 incident was not documented in the progress notes or in the TAR. C. Resident #59 (victim) 1. Resident status Resident #59, age 75, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included dementia and generalized muscle weakness. The 12/20/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. The resident was dependent or required maximal assistance with most ADLs. 2. Record review A progress note, dated 3/21/25 at 1:30 a.m., revealed a CNA reported she saw a resident in Resident #59's room sitting in his wheelchair exposing his genitals. The CNA moved the other resident out of Resident #59's room. Resident #59 remained asleep and did not appear to wake up or be aware of the incident. All parties were notified per facility protocol by the DON. A progress note, dated 3/23/25 at 11:55 p.m., revealed Resident #59 was resting in bed and did not voice any concerns to the nurse on staff. The nurse would continue to monitor the resident. An IDT note, dated 3/25/25 at 10:07 a.m., revealed on 3/21/25 at 1:30 a.m. a CNA observed a male resident in the doorway of Resident #59's room exposing his genitals. The resident was quickly removed from the room. Resident #59 was sleeping and was not aware of the man's presence. The NHA, the DON, the resident, and the resident's responsible party were notified. Interventions were put into place to prevent any recurrences. -However, the note did not specify what interventions were put into place to prevent recurrence. D. Resident #39 (victim) 1. Resident status Resident #39, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included generalized anxiety disorder, insomnia and depression. The 1/7/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident was dependent or required maximal assistance with most ADLs. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 3/21/25 at 1:30 a.m., revealed a CNA reported she saw a resident in Resident #39's room sitting in his wheelchair exposing his genitals. The CNA moved the other resident out of Resident #39's room. Resident #39 remained asleep and did not appear to wake up or be aware of the incident. All parties were notified per facility protocol by the DON. An IDT note, dated 3/25/25 at 9:43 a.m., revealed on 3/21/25 at 1:30 a.m. a CNA observed a male resident in the doorway of Resident #39's room exposing his genitals. The resident was quickly removed from the room. Resident #39 was sleeping and was not aware of the man's presence. The NHA, the DON, the resident, and the resident's responsible party were notified. Interventions were put into place to prevent any recurrences. -However, the note did not specify what interventions were put into place to prevent recurrence. E. Staff interviews CNA #6 was interviewed on 3/25/25 at 9:02 a.m. CNA #6 said Resident #62 had sexually inappropriate behaviors sometimes but never towards her. CNA #6 said she never personally witnessed any sexual behaviors from Resident #62. CNA #6 said Resident #62 was able to be redirected when he was having sexually inappropriate behaviors. CNA #6 said she knew Resident #62 had been inappropriate and masturbated in front of other CNAs. CNA #6 said Resident #62 had sexually inappropriate behaviors day and night, but was only interested in women. CNA #6 said she documented any behaviors Resident #62 exhibited into their behavior monitoring software and would notify the nurse and the social services director (SSD) if she saw any behaviors. CNA #6 said the activities department employed Resident #62 to deliver the daily bulletin to each resident's room. CNA #6 said Resident #62 would peek into residents' rooms while he delivered the news. CNA #5 was interviewed on 3/25/25 at 9:18 a.m. CNA #5 said she tried to avoid working with Resident #62 as much as possible because she had heard from other CNAs that he was inappropriate and would masturbate in front of them. CNA #5 said Resident #62 had not been inappropriate with her, but she said if he had been, she would have let the nurse know. CNA #5 said when Resident #62 distributed the daily bulletin he would slowly put them in the female residents' rooms and linger in their doorways peeking in. CNA #5 said she would close the residents' doors or redirect Resident #62 if she saw him lingering. CNA #7 was interviewed on 3/25/25 at 9:34 a.m. CNA #7 said Resident #62 would go into other residents' rooms and have sexually inappropriate behaviors. CNA #7 said Resident #62 had previously stayed in his room and not bothered anyone but after moving to a different unit, he began having behaviors. CNA #7 said Resident #62 had sexually inappropriate behaviors every two days or so and would masturbate in his room. Licensed practical nurse (LPN) #1 was interviewed on 3/25/25 at 9:58 a.m. LPN #1 said she never witnessed Resident #62 having inappropriate behaviors but she knew he would masturbate in front of staff. LPN #1 said Resident #62 had sexually inappropriate behaviors in front of ladies and was able to be redirected easily for a short time. LPN #1 said Resident #62 was moved back to the all-male secured unit for the safety of other residents after he masturbated in front of two female residents in their doorway. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Incident of physical abuse between Resident #97 and Resident #34 on 2/28/25 A. Facility investigation The facility's investigation was provided by the NHA on 3/25/25 at 1:00 p.m., revealed the following: On the morning of 2/28/25, a physical altercation was witnessed between Resident #34 and Resident #97. The altercation occurred in the hallway near Resident #34's bedroom. LPN #6 immediately separated the two residents and both residents were placed on 15-minute checks for the investigation period. LPN #6 assessed both residents and no injuries were present. Resident #34 said he could not recall the altercation with Resident #97. Resident #97 could not communicate any recollection of the incident to staff. Other residents from the unit and staff witnesses were interviewed and revealed the following: Other residents from the same unit stated that they got along with Resident #34 and Resident #97 and did not have any instances of abuse to report. The staff witnesses stated that Resident #97 was walking down the hallway and Resident #34 was in his way. Resident #34 was facing away from Resident #97. Resident #97 attempted to move Resident #34 from behind when Resident #34 reached back and made contact with Resident #97, without looking to see who was behind him. CNA #9 said that on 2/8/25 at approximately 9:30 a.m., she heard a loud noise in the hall and saw Resident #34 and Resident #97 fighting. She said she did not see any contact between the residents, but saw Resident #97 attempt to pick up his walker to hit Resident #34. She said she told Resident #97 everything was okay and tried to re-direct him away from Resident #34. She said when Resident #97 returned and walked near Resident #34 again another staff member re-directed Resident #97 back to his room and he laid down for a nap. LPN #6 said that on 2/8/25 at approximately 9:30 a.m., there was an altercation between Resident #34 and Resident #97. The altercation occurred in the hallway near Resident #34's bedroom. LPN #6 said that Resident #97 attempted to pass by Resident #34 in the hall and pushed Resident #34 aside. LPN #6 said Resident #34 became upset and attempted to hit Resident #97. LPN #6 said the situation did not escalate because the residents were separated. LPN #6 said the residents were assessed and no injuries were found. The NHA and the residents' representatives were notified. Care plans were reviewed and no changes were made. The altercation was unsubstantiated as an act of abuse. -However, abuse occurred because Resident #97 attempted to hit Resident #34 with his walker and Resident #34 retaliated and made physical contact with Resident #97. B. Resident #34 (assailant and victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #34, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia with behavioral disturbances. The 2/4/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a BIMS) of three out of 15. He walked independently but was dependent on staff assistance for all ADLs. The assessment indicated the resident had fluctuating inattention and disorganized thinking. He had delusions and physical behavioral symptoms directed toward others on one to three days during the assessment look-back review period. He had behavioral symptoms not directed toward others on a daily basis. 2. Record review Resident #34's medication care plan, revised 6/14/22, identified the resident was at risk of complications related to antipsychotic medication use for diagnoses of insomnia and dementia with behavioral disturbances. Resident #34's trigger behaviors for mood stabilizer use were impulsiveness and erratic/irrational response to stimuli. His trigger behaviors for antipsychotic use were physical aggression and erratic/irrational responses to stimuli. Interventions included administering antipsychotic medications as ordered and monitoring for any adverse side effects of medication use, consulting with pharmacy and the physician to consider dosage reduction when clinically appropriate, at least quarterly, and monitoring and documenting the resident's trigger behaviors (revised 2/18/23), giving the resident space when he was aggressive or upset, not approaching the resident from behind or the side due to the resident's visual impairments (revised 6/13/23), leading Resident #34 back to areas where staff were positioned in order to keep him visible, encouraging him to stay clear of door ways (revised 7/27/23) and keeping Resident #34 in line of sight if possible (revised 3/28/24). Resident #34's care plan for behaviors, initiated 4/13/22, revealed Resident #34 had behaviors including aggressiveness towards peers and staff and poor impulse control related to dementia, traumatic brain injury, post-traumatic stress disorder (PTSD) and a history of work as a prison guard. The resident had a history of attempting to, or threatening to hit staff. He hallucinated (reached for things that were nonexistent), had poor safety awareness and attempted to self-transfer. Resident #34's triggers included others speaking to him or about him and others approaching or touching him from the back or side and surprising him. Pertinent interventions included monitoring behavior episodes and attempting to determine the underlying cause, documenting behavior and potential causes, praising any indication of progress/improvement in behavior (initiated 4/13/22), performing frequent checks for 72 hours following any verbal or physical aggression observed or reported and providing opportunities for positive interaction and attention re-evaluation of medication management due to the resident's continued behaviors (revised 2/18/23), de-escalation by sitting with him with his back against a wall, when agitated, staff should offer him fluids and his preferred snacks (revised 3/13/23) and frequent checks and back scratches. He enjoyed being called gorgeous while having his back scratched (revised 2/26/24). A review of Resident #34's March 2025 CPO revealed the following physician's orders: Behavior monitoring for antipsychotic medication use every shift, ordered 12/12/24. Monitoring effectiveness of interventions for behaviors, ordered 12/12/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor resident every shift due to physical aggression initiated, monitor physical aggression until 2/11/25 at 11:59 p.m., ordered 2/9/25. A change in condition progress note, dated 2/8/25, revealed Resident #34 initiated an act of physical aggression. Resident #34's vital signs were within normal limits, and he had no changes in mental or physical status. The resident's representative was notified of the incident. An interdisciplinary team (IDT) progress note, dated 2/10/25, revealed Resident #34 had risk factors that contributed to his behavior, including a traumatic brain injury, dementia, poor situational and safety awareness. Interventions included separating the two residents, and for staff to ensure that other residents did not approach Resident #34 from behind. C. Resident #97 (victim and assailant) 1. Resident status Resident #97, age 85, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia with behavioral disturbances. The 1/21/25 MDS assessment documented the resident had severely impaired cognition with a BIMS score of zero out of 15. He required partial or maximum assistance for transfers and used a walker for mobility. He required touching assistance or supervision with walking. The assessment indicated the resident had daily behaviors that were not directed toward others. 2. Record review Resident #97's behavioral care plan, revised 2/3/25, revealed the resident had a behavior problem related to his dementia, language and cultural barrier and he made nonsensical statements. He had a history of physical aggression towards females and was also possessive and overprotective of his belongings, peers and partners. The resident paced and sometimes inadvertently ran into others while walking. Pertinent interventions included providing frequent checks following any verbal or physical aggression, intervening as necessary to protect others, approaching him and speaking in a calm manner, diverting his attention, removing him from the situations to an alternate location if needed, monitoring behavior episodes and attempting to determine the underlying cause, documenting behavior and potential causes, praising any indication of progress/improvement in behavior and staff to ensure the resident was not too close to others while walking in the hallway. A progress note, dated 2/8/25, revealed an altercation between Resident #34 and Resident #97 occurred in the hallway. Resident #97 attempted to pass by Resident #34, pushing Resident #34 aside. Resident #34 got upset and swung at Resident #97. The two residents were separated. No injuries were found. The NHA and Resident #97's legal guardian were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT progress note, dated 2/10/25, revealed on 2/8/25 at 12:41 p.m. there was a physical altercation between Resident #97 and another resident (Resident #34) while passing in the hallway. Resident #97 inadvertently pushed Resident #34 aside while walking past his wheelchair. Resident #34 swung at Resident #97 in response. The residents were immediately separated. No injuries were noted. The NHA was notified. Staff was to monitor for Resident #97 to have a path clear of wheelchairs while walking in the hallway. A progress note, dated 3/11/25 at 11:59 p.m., revealed completion of 72 hours of frequent 15-minute checks for Resident #97. No problems were reported. D. Staff interviews LPN #2 was interviewed on 3/26/25 at 3:28 p.m. LPN #2 said she could not remember who the aggressor was in the altercation between Resident #34 and Resident #97. She said what she remembered was that Resident #97 used to pace the hall with his walker. She said he was usually calm and collected, but at times the halls got crowded with residents. She said Resident #34 did sometimes have aggressive behaviors. CNA-Med #1 was interviewed on 3/26/25 at 3:45 p.m.CNA-Med #1 said she was not working the day of the altercation between Resident #97 and Resident #34. She said when she returned to work two days later, Resident #34 and Resident #97 were both being documented on frequently due to the altercation. She said she was told by the previous nurse that Resident #97 had been in a bad mood that day (2/8/25) and rammed his walker into the back of Resident #34's wheelchair. She said Resident #34 was easily triggered, sometimes mean, and had previously attempted to hit staff. She said staff normally walked away and let Resident #34 calm down when he was agitated, or staff who had good rapport with him would calm him down. She said she did not know if contact was made during the altercation on 2/8/25, but staff were told to keep an eye on both of the residents. She said she did not think the police were called, but families/representatives and the physician were notified. IV. Incident of physical abuse of Resident #42 by Resident #58 on 3/10/25 A. Facility investigation The facility's investigation was provided by the NHA on 3/25/25 at 1:00 p.m. revealed the following: On 3/10/25 an incident occurred between Resident #58 and Resident #42. Resident #58 allegedly made contact with another resident (Resident #42). Resident #58 attempted to kick Resident #42. The incident was witnessed by staff. Residents and staff from the unit were interviewed, statements were obtained from staff and the victim (Resident #42) was interviewed. The DON assessed Resident #42 and found no injuries. The assailant (Resident #58) was discharged to the hospital because he was unable to be redirected. Resident #42 (victim) had a history of delusions, and verbal aggression towards peers and staff. Resident #42 had a BIMS of 15 and had not been involved in any other occurrences in the past year. Resident #58 had a BIMS of three, required assistance for ADLs, and had a history of verbal and physical aggression towards staff and residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58 had become physically aggressive towards other residents when they had food he wanted. When staff attempted to re-direct him, he sometimes attempted to hit staff. Resident #58 wandered into other residents' rooms. There was a care plan for his behaviors, including a communication board, anticipating his needs, offering snacks and redirecting. Resident #58 had been involved in other occurrences of physical abuse on 11/19/24, 1/18/25, 1/20/25. Staff stated that Resident #58 had been having more behavioral episodes recently. They were unable to identify why, except that the resident had a history of being physically aggressive towards others. There were no interactions between the victim (Resident #42) and Resident #58 leading up to the incident on 3/10/25. Care plans and documentation were reviewed. The conclusion was that there was contact made but that it did not rise to the definition of abuse. -However, abuse occurred because Resident #58 willfully kicked Resident #42 (see witness statements below). Changes were made to Resident #58's plan, including discharging him to the hospital with possible re-evaluation at a future date. The police, ombudsman, family/guardian, and physician were notified. Interviews during the investigation revealed the following: On 3/10/25, CNA-Med #1 reported that she saw Resident #58 open his bedroom door, quickly walk over to the dining room and start kicking Resident #42, who was sitting in the dining room watching television. CNA-Med #1 said she separated the residents and Resident #58 shoved her into the medication cart. Other staff intervened quickly and re-directed Resident #58 back to his bedroom to lay down. Both residents were assessed and no injuries were noted. The physician, ombudsman and the corporate support person were called. Resident #58 was transferred to the hospital non-emergently. When the emergency medical technicians (EMTs) arrived, Resident #58 had to be restrained and sedated. Resident #58 was taken to the emergency room because he had become a danger to himself and others and he could not be redirected. Resident #42 was interviewed on 3/10/25 by the DON, immediately after the incident. Resident #42 said he was sitting in the dining room watching television when Resident #58 started kicking him. Resident #42 said he was fine and did not get hurt and just went back to watching television. <[TRUNCATED]

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for one (#62) of nine residents reviewed for abuse out of 36 sample residents. Specifically, the facility failed to report an incident of potential sexual abuse involving Resident #62 to the State Survey Agency (SSA). Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, was provided by the nursing home administrator (NHA) on 3/23/25 at 12:41 p.m. It read in pertinent part, Residents have the right to be free from abuse. The facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The facility will investigate and report any allegations within timeframes required by federal requirements. II. Resident #62 A. Resident status Resident #62, age 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included sexual dysfunction and major depressive disorder. The 12/17/24 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. The resident needed setup or cleanup assistance for most activities of daily living (ADL). The MDS assessment documented the resident did not have physical or verbal behaviors directed toward others or other behavioral symptoms not directed toward others. B. Record review The behavioral care plan, initiated 7/17/2020 and revised 4/14/23, revealed Resident #62 made verbally explicit comments and suggestions toward staff, masturbated in front of staff, asked female staff members if he could touch them or if the staff could touch him in a sexually inappropriate way. Pertinent interventions included explaining or reinforcing why his behavior was inappropriate or unacceptable, administering medications as ordered, educating staff on the importance of respecting Resident #62's wishes and emphasizing sexual outlet was a normal function, monitor behavioral episodes and attempt to determine an underlying cause, redirecting any inappropriate public exposure and intervening as necessary to protect the rights and safety of others. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The antipsychotic medication care plan, revised 12/30/24, revealed Resident #62 required an antipsychotic medication as evidenced by inappropriate sexual behavior, delusions and hallucinations. Pertinent interventions included administering antipsychotic medications as ordered, observing Resident #62's mood and response to the medication, and observing and recording the effectiveness of the drug treatment as indicated. A progress note, dated 3/21/25 at 12:39 p.m., revealed an unidentified CNA witnessed Resident #62 masturbating in another resident's room. The other residents slept through the situation and did not wake up. The CNA relocated Resident #62 away from the room and told the resident he could not perform those actions in others' rooms. The director of nursing (DON) spoke with Resident #62 and gave him choices to ensure his safety and the safety of others, and the resident agreed to relocate to the all-male secured unit. The nursing staff were to continue to monitor Resident #62 for hypersexual behaviors. The facility's incident investigation, undated, was provided by the NHA on 3/24/25 at 4:21 p.m. The investigation included a statement from certified nurse aide (CNA) #4, which revealed on 3/21/25 between 1:30 a.m. and 2:00 a.m., CNA #4 observed Resident #62 as he was halfway into Resident #39 and Resident #59's room. Resident #62 had exposed his genitals and was masturbating in the room. CNA #4 took Resident #62 back to his room and told him he could not be in other residents' rooms. Resident #39 was interviewed by the NHA on 3/21/25. Resident #39 said she did not have any incidents of abuse to report. Resident #39 said she felt safe in the facility. Resident #39 said she did not notice any disturbances during her sleep. Resident #39 said there was nothing else she wanted to share. Resident #59 was interviewed by the NHA on 3/21/25. Resident #59 said she did not have any incidents of abuse to report. Resident #59 said she felt safe in the facility. Resident #59 said she did not notice any disturbances during her sleep. Resident #59 said there was nothing else she wanted to share. -However, the facility failed to report the sexual abuse incident to the State Agency. III. Staff interviews The DON was interviewed on 3/26/25 at 4:40 p.m. The DON said the incident involving Resident #62 happened overnight on 3/21/25. The DON said he received a call from CNA #4 who told him she was in another resident's room, heard a noise, and saw Resident #62 halfway in the doorway of Resident #59 and Resident #39's shared room. CNA #4 said Resident #62 had his genitals exposed and was masturbating. The DON said when he came in later on the morning of 3/21/25, the facility staff interviewed Resident #62 and discussed what his next steps would be. The DON said he notified the NHA of the incident immediately. The NHA was interviewed on 3/26/25 at 5:15 p.m. The NHA said any allegations of abuse needed to be reported to him regardless of the time. The NHA said if he was not available, abuse allegations should be reported to the nurse on-call. The NHA said any abuse allegations needed to be reported to the State Agency within 24 hours. The NHA said after reporting the allegation, the facility staff would launch an investigation, ask for staff statements, and interview any residents within the vicinity of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said he was notified the morning of 3/21/25 about Resident #62's incident the night prior. The NHA said he got a statement from the CNA who witnessed the incident and that he interviewed Resident #59 and Resident #39 and they were both asleep. The NHA said he asked both of the residents if they felt safe and if they had witnessed any abuse, and neither resident expressed any knowledge of the situation. The NHA said he had not reported the incident to the State Agency as he had reached out to one of the facility's clinical consultants and was told the incident was not abuse.

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F 0689 Level of Harm - 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** 47151 Based on observations, record review and interviews, the facility failed to ensure three (#97, #37 and #47) of eight residents reviewed for accident hazards out of 36 sample residents remained as free from accidents as possible. Resident #97, who was known to be at risk for falls, was admitted on [DATE] with diagnoses of dementia, hearing impairment, unsteady and shuffling gait, and right sided weakness. The facility initiated a fall care plan which included interventions of anticipating and meeting the resident's needs, encouraging rest periods when signs of fatigue were noted, ensuring that the resident wore appropriate footwear when ambulating and keeping the resident in line of sight as needed. Resident #97 sustained falls with injury on 12/30/24 (abrasion to the right side of his head), 1/12/25 (laceration to his head) and 1/19/25 (abrasion to the back of his head). Resident #97 was sent to the emergency department (ED) for evaluation and treatment after each of the three falls. However, the facility failed to implement new fall interventions until 1/22/25 (after the third fall), when an intervention of a soft helmet for the resident to wear while awake was initiated. On 2/22/25 Resident #97 experienced another fall while ambulating in the hallway which resulted in a laceration to the back of his head and required the resident to again be sent to the ED for evaluation and treatment of a subarachnoid hemorrhage (bleeding into the space between the brain and the arachnoid membrane, one of the protective layers covering the brain). The facility failed to implement any new fall interventions upon the resident's return to the facility on [DATE]. On 2/24/25 Resident #97 experienced another fall on 2/24/25 that resulted in a large amount of bleeding to the resident's head in the same area as the resident's laceration that resulted from his fall on 2/22/25. The resident still had staples in his head from the previous fall on 2/22/25. The resident was again sent to the ED where he received six additional sutures for treatment of the laceration. The resident returned to the facility on [DATE] and the facility ordered a medical grade ribcap helmet (a medical grade helmet which offers 360 degree protection to the head). Staff interviews during the survey (see interviews below) revealed Resident #97 was not wearing the soft helmet initiated on 1/22/25 when he fell on [DATE] and 2/24/25 and the facility failed to ensure Resident #97 was encouraged to wear his safety helmet prior to his falls on 2/22/25 and 2/24/25. Due to the facility's failure to implement timely and effective interventions following each of Resident #97's falls, and the facility's failure to ensure care planned interventions were followed, the resident sustained head injuries, which required transfer to and treatment in the ED, from multiple falls. Additionally, the facility failed to ensure staff transferred Resident #37 and Resident #47 appropriately, according to their documented transfer status. Findings include: (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

I. Facility policy and procedure

The Fall and Fall Risk, Managing policy, revised March 2018, was provided by the nursing home administrator (NHA) on 3/25/25 at 3:25 p.m. It read in pertinent part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

Environmental risk factors that contribute to the risk of falls include wet floors, poor lighting, incorrect bed height or width, obstacles in the footpath, improperly fitted or maintained wheelchairs and footwear that is unsafe or absent. Resident conditions that may contribute to the risk of falls include fever, infection, delirium and cognitive impairment, pain, lower extremity weakness, poor grip strength, medication side effects, orthostatic hypertension, functional impairments, visual deficits and incontinence. Medical factors that contribute to the risk of falls include arthritis, heart failure, anemia, neurological disorders and balance and gait disorders.

If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.

The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not have been previously identified.

II. Resident #97

A. Resident status

Resident #97, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, chronic kidney disease, hearing loss, repeated falls and encephalopathy (medical conditions affecting brain function).

The 2/6/25 minimum data set (MDS) assessment revealed Resident #97 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He needed substantial assistance with transfers, used a walker and needed supervision or touching assistance with ambulation.

B. Record review

(continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #97's fall care plan, initiated 11/22/22, documented he was at risk for injury related to falls, a diagnosis of dementia, hearing impairment, unsteady and shuffling gait and right sided weakness. Pertinent interventions included anticipating and meeting the resident's needs (initiated 11/22/22), encouraging rest periods when signs of fatigue were noted (initiated 11/22/22), ensuring that the resident wore appropriate footwear when ambulating, (initiated 11/22/22), educating the resident, family and caregivers about safety reminders and what to do if a fall occurred (initiated 7/7/23), resident to be in line of sight as needed (initiated 3/6/24), soft helmet while awake (initiated 1/22/25), staff to ensure the resident was not too close to others while walking in the hallway (initiated 1/22/25) and medical-grade helmet (initiated 2/24/25). A review of Resident #97's electronic medical record (EMR) revealed the following progress notes: A 12/30/24 charting note, documented at 8:00 p.m,. revealed that Resident #97 had a fall. The resident was using a walker, going too fast and lost his balance. The resident was wearing non-skid socks on both feet and his walker was in front of him. The resident hit his head, either on the dresser or the night stand, and had an abrasion to the right side of his head and an egg-sized lump. The resident was not taking any anti-coagulant medications (blood thinners). The resident had major difficulty attempting to walk to his bed and kept holding his head at the site of impact. The resident was sent out to the ED for evaluation. A 12/31/24 charting note, documented at 11:15 p.m., revealed that Resident #97 returned from the hospital at 11:15 p.m. The resident had another fall while in the hospital. -The facility failed to initiate any new fall interventions following the resident's 12/30/24 fall (see care plan above). A 1/3/25 weekly summary note, documented at 9:55 a.m., indicated that Resident #97 had no falls or injuries the previous week. -However, the resident progress notes documented the resident had a fall on 12/30/24 that resulted in an abrasion to the right side of his head and an egg-sized lump. A 1/10/25 progress note, documented at 11:36 a.m., revealed that the floor staff observed Resident #97 with worsened balance, leaning to the right side, and staff had to watch the resident closely and provide physical support when walking at times with a walker. A 1/13/25 interdisciplinary team (IDT) note, documented at 9:41 a.m., revealed that on 1/12/25 at 2:00 a.m., Resident #97 was seen sliding to the floor by a certified nurse aide (CNA). Resident #97 hit the back of his head and sustained a laceration to the head without a change of consciousness. The resident was sent to the ED for evaluation. -The facility failed to initiate any new fall interventions following the resident's 1/12/25 fall (see care plan above). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 1/19/25 charting note, documented at 6:45 p.m., revealed that Resident #97 had a fall in the hallway while other residents were gathering for a cigarette break. The resident hit his head multiple times on the wall when he fell . Neurological assessments and frequent checks were initiated and the resident was found to have an abrasion to the back of his head approximately three centimeters (cm) in diameter. The nurse on the unit notified the physician and the resident was sent to the ED for further evaluation. A 1/24/25 note, documented at 11:40 a.m., revealed that Resident #97 continued on therapy services three times a week for a fall and decreased strength. The resident continued to use a four-wheeled walker for ambulation and did very well unless he was tired. Staff encouraged the resident to rest between meals and when he was noticeably becoming unstable, as evidenced by the resident beginning to [NAME] to the right and run into walls. The resident could be difficult to redirect due to a language barrier and dementia diagnosis. A 2/21/25 progress note, documented at 6:43 p.m. revealed that Resident #97 continued to use a walker to ambulate in the hallways. He was encouraged to wear a helmet and to take rest breaks through the day, but was resistant to this guidance. -However, the resident's fall care plan failed to indicate the resident refused to wear his helmet or take rest breaks (see care plan above). A 2/22/25 progress note, documented at 3:15 a.m., revealed that Resident #97 was walking in the hallway with a walker and fell on his back, resulting in a laceration to the back of his head. Pressure was applied to stop the bleeding. The resident was able to squeeze a staff member's hand and sit upright on his own. A registered nurse (RN) was notified. The resident was sent to the hospital for treatment and evaluation. -The progress note failed to document if Resident #97 was wearing a protective soft helmet, per the care planned interventions on 1/22/25 (see care plan above). -The facility failed to document refusals by Resident #97 to wear the care planned soft helmet or attempts by staff to encourage the resident to wear it. -The facility failed to initiate any new fall interventions following the resident's 2/22/25 fall (see care plan above). A 2/23/25 progress note, documented at 12:04 p.m., revealed that Resident #97 was readmitted to the facility, was confused and wandering frequently between hallways and his room. The resident required frequent staff monitoring for high risk of falling. A 2/23/25 progress note, documented at 4:10 p.m., revealed that Resident #97 returned to the facility from the hospital for treatment of a subarachnoid hemorrhage following a fall at the facility. The resident had sutures on the back of his head. A 2/24/25 progress note, documented at 6:50 p.m., revealed that a staff member was called to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	come and help with Resident #97 due to a fall and a large amount of bleeding to the resident's head. The resident still had staples in his head from his previous fall on 2/22/25. Staff applied pressure to the resident's wound and the resident was sent out to the ED for further evaluation. A 2/24/25 progress note, documented at 11:43 p.m., revealed that Resident #97 returned to the facility with a head laceration that was repaired with six additional sutures. The resident had a 10 cm laceration to the back of his head and returned to the facility at 10:05 p.m. -The progress note failed to document if Resident #97 was wearing a protective soft helmet, per the care planned interventions on 1/22/25. -The facility failed to document refusals by Resident #97 to wear the care planned soft helmet or attempts by staff to encourage the resident to wear it. A 2/25/25 nurse's note, documented at 4:07 p.m., revealed that a ribcap helmet was ordered for Resident #97and staff were to encourage the resident to wear the helmet, and the resident's care plan was updated. The resident was to have a one-to-one sitter until the helmet was received. A 2/28/25 progress note documented, at 9:31 a.m., revealed that Resident #97's therapy for fall risk had been discontinued. The resident had fallen in the past week with head injuries and had been under one-to-one staff supervision. According to the hospital physician, the resident had a history of stroke which caused him to walk with weight on his heels and he was prone to falling backward. Review of Resident #97's post-fall assessments revealed the following: A 12/30/24 post-fall assessment was completed for Resident #97 and he was categorized as a moderate fall risk. The post-fall assessment documented the resident had multiple falls the last six months and strayed off the straight path of walking but failed to document the resident used a walker. A 1/15/25 post-fall assessment was completed for Resident #97 and he was categorized as a moderate fall risk and strayed off the straight path of walking. However, the post-fall assessment documented the resident had one to two falls in the last six months, contrary to the previous assessment on 12/30/24 that documented he had multiple falls in the same time frame. The 1/15/25 assessment additionally failed to document the resident used a walker. A 1/20/25 post-fall assessment was completed for Resident #97 and he was categorized as a moderate fall risk. The post-fall assessment documented the resident had multiple falls in the last six months and strayed off the straight path of walking. However, the resident's use of psychotropic medications and laxatives were not documented on the assessment and the assessment failed to document that the resident used a walker. A 2/25/25 post-fall assessment was completed for Resident #97 and he was categorized as a moderate fall risk. The post-fall assessment documented the resident had one to two falls in the last six months and the resident's use of psychotropic medications and laxatives were not indicated on the assessment. The assessment documented the resident used a walker. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However, the resident had five falls in the last 60 days (see above) and was ordered risperidone starting 1/30/25, neither of which was indicated on the assessment. The assessment additionally failed to document the resident strayed off the straight path of walking as indicated on the previous post fall assessments (12/30/24, 1/15/25, 1/20/25). The fall investigations for Resident #97's falls on 2/22/25 and 2/24/25 were provided by the NHA on 3/24/25 at 3:23 p.m. -The fall investigations failed to document if Resident #97 was wearing a soft helmet as a fall prevention. C. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 3/25/25 at 2:55 p.m. LPN #4 said Resident #97's fall on 2/22/25 occurred near the end of her shift. LPN #4 said the resident would walk around with a walker several times during the course of the night. LPN #4 said he would take his walker and follow around the edge of the wall, catching the wheel of his walker on the wall, and he would do that several times during the night. LPN #4 said she told the CNAs to keep an eye on Resident #97 and that the resident had a history of falling backwards. LPN #4 said when Resident #97's fall occurred on 2/22/25, she was at the medication cart and passing medications. She said the resident was bleeding a lot from his head and was sent to the hospital. LPN #4 said there was a physician's order for the resident to wear a helmet from a previous fall, but the helmet did not fit and the resident would not wear it. LPN #4 said the order was discontinued and he did not have a current order for a helmet. LPN #4 said she had the CNAs check the room for a helmet but they were unable to locate one. CNA #8 was interviewed on 3/25/25 at 3:00 p.m. CNA #8 said when Resident #97 fell on [DATE], staff were getting a group of residents together to smoke and Resident #97 was ambulating with a walker. CNA #8 said Resident #97 was supposed to have a special helmet but the resident took the helmet off. CNA #8 said the resident was on every 15-minute checks and was supposed to be getting a hard helmet. CNA #8 said the resident did wear the grippy socks. She said he was not wearing a helmet when he fell a second time on 2/24/25. The director of nursing (DON) and the NHA were interviewed together on 3/26/25 at 10:20 a.m. The DON said the facility had a soft shell to fit inside the normal hat Resident #97 wore regularly. The DON said it was care planned to encourage Resident #97 throughout the shift to wear his protective helmet and there was no set amount of times to remind him. -However, the care plan did not indicate staff were to encourage the resident to wear his protective helmet (see care plan above). The DON said staff tried to anticipate Resident #97's behavior. The DON said a soft shell helmet would benefit Resident #97 more when he was ambulating. The DON said the resident did not wear the rib cap helmet in the bed due to skin breakdown. The DON said Resident #97 swatted at his hand when he had tried to put the helmet on him. The NHA said Resident #97 was not wearing his helmet when he fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	III. Resident #37 A. Resident status Resident #37, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke), type 2 diabetes mellitus, dementia, anxiety, difficulty walking and heart failure. The 12/31/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of five out of 15. The resident was dependent on care for all activities of daily living (ADL) except eating, where she needed set up assistance. The MDS assessment did not document use of a mechanical lift or prior falls. B. Record review Resident #37's fall care plan, revised 11/6/24, documented she was at high risk for falls due to incontinence, paralysis, psychoactive drug use, was unaware of safety needs and declined therapy. Pertinent interventions, revised 4/1/24, included to anticipate and meet Resident #37's needs. A fall mat intervention was initiated 10/11/24. Resident #37's ADL care plan, revised 7/16/24, documented she had a self care performance deficit due to hemiplegia and dementia. Pertinent interventions, initiated 7/16/24, included that Resident #37 was totally dependent on staff for repositioning and turning in bed and required a hoyer lift (mechanical lift) with two staff members for transfers. A 3/23/25 nursing progress note, documented at 7:30 p.m., revealed that a CNA was transferring Resident #37 into bed. The CNA then came out of the room and said the resident was on the floor. The CNA said that she lowered the resident to the floor. Resident #37's 3/23/25 fall investigation was provided by the NHA on 3/24/25 at 3:23 p.m. The fall investigation documented Resident #37's fall happened during a transfer and the CNA said the resident tripped over oxygen tubing and the floor mat was also in the way during the transfer. -However, per Resident #37's ADL care plan, the resident was supposed to be a two-person transfer with a hoyer lift (see care plan above). Resident #37's 3/24/25 post-fall assessment documented the resident's gait analysis as unable to independently come to a standing position. C. Staff interviews CNA #3 was interviewed on 3/25/25 at approximately 3:00 p.m. CNA #3 said Resident #37 needed a mechanical lift for transfers and the assistance of two staff members to transfer. CNA #3 said she was aware Resident #37 had fallen previously. CNA #3 said Resident #37 could transfer while standing from her bed to her chair but needed to have two staff members assist her closely and she usually used the mechanical lift for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 3/26/25 at 10:20 a.m. The DON said Resident #37's care plan indicated the mechanical lift was to be used to transfer Resident #37. The DON said it was against company policy to transfer Resident #37 without the mechanical lift. The DON said the facility staff directly transferred the resident to her bed without the mechanical lift on 3/23/25 and one CNA was present in the room at the time instead of two. 50219 IV. Resident #47 A. Resident status Resident #47, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included multiple sclerosis (a disease that causes breakdown of the protective covering of nerves), history of traumatic brain injury, epilepsy and encephalopathy (a medical condition that affects brain function). The 2/13/25 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS assessment score of 12 out of 15. The resident was dependent on staff for most ADLs. The assessment documented the resident was dependent on staff for all transfers. B. Record review The functional abilities care plan, revised 8/1/24, revealed Resident #47 required staff assistance with ADLs due to his multiple sclerosis and history of traumatic brain injury. Pertinent interventions included Resident #47 requiring extensive total assistance with bathing and showering and requiring a hoyer lift with two staff members for transfers, revised 10/18/24. The fall care plan, initiated 12/16/24 and revised 2/12/25, revealed Resident #47 was at risk for falls due to altered balance while standing, a history of falls and an unsteady gait. Pertinent interventions included having two staff members to assist with transfers with a hoyer lift (initiated 4/29/24), engaging with Resident #47 and reminding him to stay seated until the hoyer lift transfer was complete (initiated 6/30/24) and only using the hoyer lift for transfers (initiated 2/6/25). -However, the resident had already had an intervention for transfers with two people and a hoyer lift which was initiated on 4/29/24, 10 months prior to the hoyer lift intervention implemented on 2/6/25. The facility fall report, dated 12/31/24 at 10:45 a.m., revealed Resident #47 was receiving a shower when he fell . An unidentified CNA was transferring Resident #47 to a chair when the resident slipped, the CNA was unable to hold him and the resident fell . According to the CNA, Resident #47 hit his head on the wall. No injuries or bruises were observed during the nurse's assessment and Resident #47's range of motion and behavior were at baseline. The RN was notified. The report documented physiological factors contributing to the fall included weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A change in condition form, dated 12/31/24 at 11:57 a.m., revealed Resident #47 fell in the shower room. Resident #47 slipped during a transfer and fell down. Resident #47 hit his head on the wall during the fall. Resident #47 was not in distress and his vital signs were within normal limits. A post-fall rehabilitation screening, dated 12/31/24 at 1:55 p.m., revealed Resident #47 fell during an assisted transfer. Resident #47 was dependent for transfers, and the physical therapist recommended using a mechanical lift and rolling shower chair for showers. -However, per the resident's care plan, the resident had required the use of a hoyer lift for transfers since 4/29/24 (see care plan above). An interdisciplinary team (IDT) note, dated 1/2/25 at 9:32 a.m., revealed that on 12/31/24 at approximately 10:45 a.m., Resident #47 was in the shower room with a shower aide and slipped on the floor. The CNA reported Resident #47 hit his head. Risk factors included the lift protocol was not followed and Resident #47 was impulsive and had poor safety awareness. Prior interventions included having physical therapy evaluate Resident #47, a floor mat by Resident #47's bedside and his bed in the lowest position. Interventions put into place included re-educating staff on the facility's lift policy. The facility fall report, dated 2/6/25 at 6:43 p.m., revealed Resident #47 had a witnessed fall. The report documented an unidentified CNA called the nurse into Resident #47's room around 4:30 p.m. to assist the resident on the floor in his room. The nurse entered Resident #47's room and observed him lying down on the floor. The RN in the building was called to assess Resident #47. No physical injuries were noted at the time and Resident #47 said he was tired and wanted to stay in bed. Resident #47 was assisted by four staff members back into bed, his vital signs were taken and a neurological assessment was performed. An IDT note, dated 2/7/25 at 10:32 a.m., revealed that on 2/6/25 at 6:43 p.m., Resident #47 was assisted to the floor by a CNA during a transfer due to weakness. No pain or injuries were identified. Resident #47 was assisted back into his bed per his request by four staff members. Resident #47 stated he was tired. Risk factors included weakness, dementia and a history of falls. Prior interventions included having physical therapy evaluate and treat Resident #47, a floor mat on Resident #47's bedside and his bed in lowest position, and re-educating the staff on the facility lift policy. Interventions initiated included only using a hoyer lift for transfers. -However, per the resident's care plan, the resident had required the use of a hoyer lift for transfers since 4/29/24 (see care plan above). A post-fall rehabilitation screening, dated 2/7/25 at 1:49 p.m., revealed Resident #47 was attempting to transfer during the fall. The physical therapist recommended using a mechanical lift for improved safety with transfers. -However, per the resident's care plan, the resident had required the use of a hoyer lift for transfers since 4/29/24 (see care plan above). C. Staff interviews (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #5 was interviewed on 3/26/25 at 9:30 a.m. CNA #5 said Resident #47 needed to be transferred using a hoyer lift. CNA #5 said Resident #47 could stand with two staff members assisting him early in the mornings, and mainly needed to use the hoyer lift after lunch. -However, according to the resident's care plan, the resident was to be a hoyer lift for all transfers (see care plan above). CNA #2 was interviewed on 3/26/25 at 10:13 a.m. CNA #2 said Resident #47 usually needed to use a hoyer lift to transfer. CNA #2 said in the mornings, if Resident #47 felt good he could stand, but he generally needed to use the hoyer lift. CNA #2 said they would often only have one CNA to operate a hoyer lift rather than two, but over the last two months they had enough staff to have two staff members operating the hoyer lifts. LPN #1 was interviewed on 3/26/25 at 10:34 a.m. LPN #1 said Resident #47 needed to transfer with the hoyer lift, but sometimes had good days where he did not need to use the lift. LPN #1 said Resident #47 needed to use the hoyer lift since he had a decline the month prior. -However, according to the resident's care plan, the resident had been care planned to use a hoyer lift for transfers since 4/29/24 (see care plan above). The director of rehabilitation (DOR) was interviewed on 3/26/25 at 12:56 p.m. The DOR said Resident #47 needed to be transferred with a hoyer lift at all times. The MDS coordinator (MDSC) was interviewed on 3/26/25 at 3:36 p.m. The MDSC said Resident #47 needed to be transferred using the hoyer lift exclusively. The MDSC said Resident #47 had multiple sclerosis and was wheelchair-bound when he was admitted but had experienced a continuous decline in mobility. The MDSC said Resident #47 used to transfer by stand and pivot method but had a few falls in which his legs buckled under him. The MDSC said Resident #47's fall in February 2025 was related to a transfer during which he tried to self-transfer and was caught by the facility staff. The MDSC said Resident #47's fall in December 2024 occurred as a CNA was transferring him in the shower room and he fell . The DON was interviewed on 3/26/25 at 4:40 p.m. The DON said Resident #47 needed to be transferred with a hoyer lift at all times. The DON said Resident #47 used to transfer via stand and pivot a year prior (2024). The DON said Resident #47's fall on 12/31/24 went directly against the facility's no-lift policy. The DON said Resident #47 was a known hoyer lift user and the resident could not coordinate balancing weight on his legs. The DON said the CNA was trying to transfer Resident #47 to his wheelchair when he fell on [DATE]. The DON said Resident #47's fall on 2/6/25 was unwitnessed. The DON said Resident #47 had rolled out of bed and onto the floor. -However, the facility fall report documented Resident #47's fall as witnessed, and the IDT note on 2/7/25 documented the fall occurred during a transfer and the CNA lowered the resident to the floor due to weakness (see record review above).

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47151 Based on observations, record review and interviews, the facility failed to ensure residents received food and fluids prepared in a form designed to meet his or her needs. Specifically, the facility failed to ensure residents who were prescribed mechanically altered diets had food prepared according to their diet orders of puree and mechanical soft as indicated on their meal tray cards. Findings include: I. Facility policy and procedure The Therapeutic Diets policy, undated, was provided by the nursing home administrator (NHA) on 3/26/25 at 11:32 a.m. It read in pertinent part, Diet orders should match the terminology used by the food and nutrition services department. A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: altered consistency diet. If a mechanically altered diet is ordered, the provider will specify the texture modification. The dietitian, nursing staff and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. II. Record review The menu extensions and modifications for modified texture diets were provided by the dietary director (DD) on 3/26/25 at 5:00 p.m. The menu extensions documented the following modifications for the mechanically altered food items served during lunch meal service on 3/25/25: -The regular diet included beef tostadas, shredded lettuce and tomato, ground green chili stew and fruit crisp. -The mechanically altered diet included puree beef tostadas, no lettuce and tomato, ground green chili stew and sliced peaches. -However, the modified texture diet menu extensions did not specifically state a mechanical soft altered diet as listed on the resident's meal tickets, but listed a mech altered diet. The extensions also included IDDSI mince and moist level five and soft and bite size level six which the facility had not yet transitioned to use (see the interviews below). III. Meal service observation and test tray During a continuous observation on 3/25/25, beginning at 11:10 a.m. and ending at 12:37 p.m., the following was observed during the meal preparation and service in the main kitchen: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The posted menu was beef tostada with shredded lettuce and tomato and fruit crisp. At 11:21 a.m. a resident's lunch plate was assembled by cook (CK) #1 with a crisp, fried tostada shell topped with ground beef and a fruit crisp was placed on the tray by dietary aide (DA) #1. The meal ticket on the tray documented a mechanical soft-ground texture and the tray was placed in a cart for delivery. -However, according to the meal extensions, the resident should have received a pureed beef tostada. (see meal extensions above) All 11:22 a.m. a residents meal tray was assembled by CK #1. DA #1 placed a fruit crisp on the tray. The meal ticket on the tray documented a mechanical soft-ground texture and the tray was placed in a cart for delivery. -However, according to the meal extensions, the resident should have received peach slices, not fruit crisp (see meal extensions above). At 11:33 a.m. a resident's lunch plate was assembled by CK #1 with a crisp, fried tostada shell topped with ground beef. The meal ticket on the tray documented a mechanical soft-ground texture. -However, according to the meal extensions, the resident should have received a pureed beef tostada. (see meal extensions above) At 12:00 p.m. a puree plate was prepared and served to a resident. The plate consisted of puree meat, mashed potatoes and a puree green vegetable. The resident's meal ticket documented a puree diet texture. -The puree vegetable served to the resident included peas which should not have been pureed (see interview below). At 12:16 p.m. the DD said to CK #1 that the fried tostada shells were a choking hazard. At 12:20 p.m. the DD removed the puree meat from the steam table and placed the puree meat in a food processor to blend the food. The DD said he wanted to make sure the food was the right consistency. The puree meat was placed back in the steam table for meal service. At 12:00 p.m. a puree plate was prepared and served to a resident. The plate consisted of puree meat, mashed potatoes and a puree green vegetable. -The puree vegetable served to the resident included peas which should not have been pureed (see interview below). At 12:31 p.m. The DD said to CK #1 that for a mechanical soft diet texture the tortilla should always be bite size and soft while he cut a soft flour tortilla and placed the pieces on a plate. The DD said he had not reviewed the modified texture diet menu extensions. -However, according to the meal extensions, the resident should have received a pureed beef tostada and not a cut-up soft flour tortilla. (see meal extensions above) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverdale Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2311 E Bridge St Brighton, CO 80601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:35 p.m. a puree test tray was provided. The puree texture test tray consisted of puree beef, mashed potatoes, pureed peas and carrots and chocolate pudding for dessert. -The puree vegetable served to the resident included peas which should not have been pureed (see interview below). -The peas and carrots provided on the test tray had visible pieces of carrots and peas in the puree peas and were not smooth. The puree meat had small visible lumps. IV. Staff interviews CK #1 and the DD were interviewed together on 3/25/25 at approximately 12:30 p.m. (during meal service). CK #1 said the facility had a book of modified texture diet menu extensions in the kitchen. The DD said the facility had modified texture diet menu extensions but he needed to check with the registered dietitian (RD) to see if the modified texture diet menu extensions were correct. The DD and the NHA were interviewed together on 3/26/25 at 12:00 p.m. The DD said the facility was transitioning to IDDSI and was in the process of training the staff to the proper standards on IDDSI. The DD said the residents prescribed a puree diet had received puree peas and carrots for lunch on 3/25/25. The DD said the staff should not have pureed the peas and he noticed the puree peas after the meals had been sent to residents. The DD said a food with a hull, such as peas, should not be pureed. The DD said the facility would transition to minced and moist level five and soft and bite size level six diet textures (of IDDSI diets) to replace the mechanical soft diet texture the facility used. The DD said he was notified during lunch by facility staff the modified diet textures were incorrect, but it was too late to do anything about it. The DD said if modified textures were served incorrectly the residents were at risk for choking. The NHA said all staff were trained during their initial onboarding on how to recognize modified textures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 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 in three of three unit nourishment refrigerators. Specifically the facility failed to: -Ensured the nourishment room refrigerators were maintained at a safe temperature; -Ensure health shakes were labeled in the unit nourishment refrigerators; and, -Ensure the floor, walls and ice machine in the main kitchen were maintained in a clean and sanitary condition. Findings include: I. Ensure safe cold food holding temperatures were maintained and health shakes were labeled in the nourishment refrigerators A. Professional reference The Colorado Retail Food Establishment Rules and Regulations, ([DATE]), retrieved on [DATE], read in pertinent part, Except during preparation, cooking, or cooling, or when time is used as the public health control time/temperature control for safety food shall be maintained at 135 degrees fahrenheit (F) or above at 41 F or less. (,d+[DATE].16) B. Observations On [DATE] at 10:30 a.m. the following was observed in a south unit nourishment refrigerator and freezer: -Six health shake cartons; the directions printed on the side of the carton read to use the thawed product within 14 days. There was no pull date or written expiration date on the thawed health shakes; -There was brown liquid splattered on the sides and spilled on the bottom of the freezer and inside the door shelf; and, -A box of turkey pot pie was in the freezer with an expiration date of [DATE] with a name written on the box. On [DATE] at 2:25 p.m. the following was observed in the south unit nourishment refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was brown liquid splattered on the sides and spilled on the bottom of the freezer and inside the door shelf; -A box of turkey pot pie in the freezer with an expiration date of [DATE]; and, -Nine health shake cartons; the directions printed on the side of the carton read to use the thawed product within 14 days. There was no pull date or written expiration date on the thawed health shakes. The [DATE] ([DATE] to [DATE]) temperature log for the south unit nourishment refrigerator was reviewed. The temperatures were recorded as follows: -On [DATE] the temperature was 42 F. -On [DATE] the temperature was 46 F. -On [DATE] the temperature was 42 F. -On [DATE] the temperature was 45 F. -On [DATE] the temperature was 48 F. -On [DATE] the temperature was 45 F. -On [DATE] the temperature was 43 F. -The recorded refrigerator temperatures were above the acceptable cold holding temperature of 41 F and there was no evidence to indicate the temperature was corrected (see professional reference above). An unidentified certified nurse aide (CNA) looked at the frozen turkey pot pie with the expiration date of [DATE] and said the resident whose name was written on the box was no longer at the facility and placed the expired product back in the freezer. On [DATE] at 2:40 p.m. the following was observed in the men's secured unit nourishment refrigerator: -Three health shake cartons; the directions printed on the side of the carton read to use the thawed product within 14 days. There was no pull date or written expiration date on the thawed healthsakes. On [DATE] at 2:45 p.m. the following was observed in the Aspen unit nourishment refrigerator : -Seven health shake cartons; the directions printed on the side of the carton read to use the thawed product within 14 days. There was no pull date or written expiration date on the thawed healthsakes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The [DATE] ([DATE] to [DATE]) temperature log for the aspen unit nourishment refrigerator was reviewed. The temperatures were recorded as follows: -On [DATE] the temperature was 42F. -On [DATE] the temperature was 42 F. -On [DATE] the temperature was 42 F. -On [DATE] the temperature was 48 F. -On [DATE] the temperature was 46 F. -The recorded refrigerator temperatures were above the acceptable cold holding temperature of 41 F and there was no evidence to indicate the temperature was corrected (see professional reference above). C. Staff interviews The director of nursing (DON) was interviewed on [DATE] at approximately 3:25 p.m. The DON said the dietary staff managed the unit nourishment refrigerators. CNA #2 was interviewed on [DATE] at approximately 2:30 p.m. CNA #2 said the overnight nursing staff checked the nourishment refrigerator temperatures and removed expired products. Certified nurse aide with medication aide (CNA-Med) #1 said the night shift usually checked the nourishment refrigerator temperatures and she said she would check the temperatures of the nourishment refrigerators again for accuracy. The dietary director (DD) and the nursing home administrator (NHA) were interviewed together on [DATE] at 12:00 p.m. The NHA said the dietary department was responsible for recording the nourishment refrigerators temperatures and checking for expired products. The NHA said the nourishment refrigerator in the south unit was running a high temperature (out of range) because the thermometer was in the door but they moved the thermometer back inside the refrigerator. She said when they moved the thermometer the temperature was reading within normal limits. The DD said that unit refrigerator temperatures and maintenance of the product would be corrected. The DD said since the refrigerator temperatures were running high, the staff should take the temperature of the food in the refrigerator to ensure it was a safe temperature, and if the food was not a safe temperature after 30 minutes the food would be discarded. The DD said he was going to go through the product in the unit refrigerators and clean them out. The NHA said he was not sure if the facility provided education to the CNAs on refrigerator temperature maintenance so they would notice if the temperature was out of range during their use of the refrigerators. II. Maintain a clean and sanitary kitchen environment (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Professional reference The Colorado Retail Food Establishment Rules and Regulations, ([DATE]), retrieved [DATE] read in pertinent part, Materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: smooth, durable, and easily cleanable for areas where food establishment operations are conducted; and nonabsorbent for areas subject to moisture such as food preparation areas, walk-in refrigerators, warewashing areas, and areas subject to flushing or spray cleaning methods. (,d+[DATE].11) B. Facility policy and procedure The Sanitization policy, revised [DATE], was provided by the NHA on [DATE] at 11:32 a.m. It read in pertinent part, All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris and protected from rodents and insects. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. Ice machines and ice storage containers are drained, cleaned and sanitized per manufactures instructions. C. Observations The initial kitchen tour was conducted on [DATE] at 9:10 a.m. The following was observed: -Approximately ten missing coving tiles (a curved tile that transitions the floor to the wall) behind the ice machine extending under the clean side of the dish machine table. The pipe extending from the back of the ice machine was dripping onto the floor instead of the drain and created standing water that pooled into the grout between the existing floor tiles. Four coving tiles were damaged and separated from the wall. The wall behind the ice machine was bowed out into the kitchen; -The aluminum filter on the back of the ice machine was caked with brown debris; and, -A large section extending approximately ten feet long and a foot wide revealed an exposed, uneven and rough concrete floor that was missing kitchen floor tiles. A kitchen walk through was conducted in the main kitchen on [DATE] from 11:10 a.m. through 1:30 p.m. The following was observed: -Approximately ten missing coving tiles behind the ice machine and extending under the clean side of the dish machine table (a curved tile that transitions the floor to the wall) were missing. The pipe extending from the back of the ice machine was dripping onto the floor instead of the drain and created standing water that pooled into the grout between the existing floor tiles. Four coving tiles behind the ice machine were damaged and separated from the wall. The wall behind the ice machine was bowed out into the kitchen; -The aluminum filter on the back of the ice machine was caked with brown debris; and, -A large section extending approximately ten feet long and a foot wide revealed an exposed, uneven and rough concrete floor that was missing kitchen floor tiles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Staff interviews The NHA was interviewed on [DATE] at approximately 3:30 p.m. The NHA said he was not aware that the filter on the back of the ice machine had not been cleaned and had not seen the tiles behind the dish machine. He said he was not aware the ice machine was dripping onto the floor. The NHA said the kitchen floor was missing tiles because a broken pipe had been repaired and the facility would repair the floor in house. The DON was interviewed on [DATE] at approximately 3:30 p.m. The DON said it looked like the ice machine had been moved from where it usually sat The DD and the NHA were interviewed together on [DATE] at 12:00 p.m. The NHA said he was not sure if the ice machine filter had been assigned to anyone to clean. He said it was possible the ice machine filter should have been cleaned as part of the regular clean performed by their contacted vendor. E. Facility follow up On [DATE] at 11:32 a.m. the NHA provided documentation that the facility reached out to a local vendor on [DATE] for a quote on epoxy chip coating (seamless) the kitchen floor. No further documentation was provided if the local vendor provided the quote.