STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065386	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado State Veterans Nursing Home - Rifle	851 E 5th St Rifle, CO 81650

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observation, record review and staff interviews, the facility failed to ensure three (#12, #26 and #52) of seven residents reviewed for abuse out of 41 sample residents was kept free from abuse. Specifically, the facility failed to: -Protect Resident #12 from physical abuse from a staff member; and, -Protect Resident #26 from verbal abuse from Resident #52. Findings include: I. Facility policy and procedure The Abuse policy, revised 9/19/24, was provided by the nursing home administrator (NHA) on 11/18/24 at 1:21 p.m. The policy read in pertinent part, It is the policy of the facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent mistreatment, abuse, neglect, and exploitation (MANE). The facility will take necessary precautions to prevent resident abuse by anyone including staff members, other residents, volunteers, contracted staff, family members, resident representatives, visitors, and any other individuals. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The facility employees and contractors will be educated on MANE during initial orientation. Existing staff will receive annual education and as needed. Training topics should include: -Types of abuse; -Prohibiting and preventing all forms of MANE; (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Identifying what constitutes MANE; -Recognizing signs of MANE, such as physical or psychosocial indicators; and, -Reporting process for MANE, including injuries of unknown sources. Understanding behavioral symptoms of residents that may increase the risk of MANE such as: -Aggressive and/or catastrophic reactions of residents; -Wandering or elopement-type behaviors; -Resistance to care; -Outbursts or yelling out; and, -Difficulty in adjusting to new routines or staff. II. Allegation of physical abuse of Resident #12 from certified nurse aide (CNA) #2 A. Allegation of physical abuse on 11/11/24 The 11/11/24 alleged abuse incident report was provided by the director of nursing (DON) on 11/20/24 at 1:49 p.m. Resident #12 alleged that a male CNA (CNA #2) held/grabbed his arms during care that the resident did not want done. The resident reported the allegation to the DON and the lead CNA on 11/11/24 at 1:38 p.m. Resident #12 reported that the male CNA (CNA #2) held/grabbed his arms so another staff member could change him when he refused wanting to be checked and changed. According to the incident report, the resident was alert and oriented and immediately assessed for injury. The assessment of the resident's right hand identified Resident #12 had a small crescent moon shaped bruise on the back side between his thumb and his first finger. He had multiple red marks on his left arm that the resident said were bruises, however, the marks were consistent with various red age spots on both his arms. According to the incident report, the facility started an investigation after the allegation of the abuse. The NHA provided the 11/11/24 alleged abuse occurrence investigation packet on 11/19/24 at 4:25 p.m. According to the alleged abuse occurrence investigation, Resident #12 reported CNA #2 entered his room on 11/11/24 at 3:00 a.m. and held him down to change his brief. The alleged abuse occurrence investigation documented the alleged assailant was placed on administrative leave pending the investigation, a skin assessment was completed for Resident #12 and other staff and residents were interviewed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/11/24 interview with Resident #12 documented Resident #12 reported to the DON two staff members requested to change the resident's brief. Resident #12 declined the request which prompted CNA #2 to hold the resident's arms while the other CNA changed his brief. According to the documented interview, Resident #12 was yelling out as his arms were held and his brief was changed. The 11/11/24 interview with CNA #2 documented CNA #2 said he entered Resident #12's room and the resident was yelling at him and told him to leave his room. CNA #2 said he left the room and reported the interaction to the night shift nurse. According to the documented interview, CNA #2 said he later returned to the room with CNA #3 to change Resident #12. CNA #2 reported the resident became physically and verbally aggressive. The 11/11/24 documented interview with CNA #2 further revealed CNA #2 said he grabbed Resident #12's arm to prevent him from hitting CNA #3. CNA #2 said he did not leave the room when the resident was upset because he was told by CNA #3 that Resident #12 needed to be changed on the last rounds, no matter what. The documented interview indicated CNA #2 and CNA #3 received education from the night shift nurse to leave the situation next time and report the resident's refusal to the nurse. The 11/11/24 documented interview with CNA #3 identified CNA #3 witnessed CNA #2 grab Resident #12's arms to prevent the resident from hitting her face. The 11/11/24 alleged abuse occurrence investigation packet identified four other residents and three other staff members were interviewed as part of the initial investigation. A staff interview with CNA #4 documented another resident (Resident #37) told her CNA #2 was a bit rough in his approach and felt he could benefit from some additional training. The summary of the investigation included in the 11/11/24 alleged abuse occurrence investigation packet documented Resident #12 was combative and struck CNA #3 when she was providing cares so CNA #2 held his arm back to prevent her from being hit. According to the summary, CNA #3 felt there was no malicious intent of CNA #2 with his actions, no other residents expressed fear or experienced injury from a staff member and Resident #12 had no behavioral changes after the incident. The summary of the investigation indicated the documentation following the incident did not identify Resident #12 had new bruises or injuries consistent with the allegation noted to his arms following the incident. According to the summary, the resident had a small one centimeter (cm) bruise in between his thumb and index finger where he would normally grip his wheelchair. The summary of the investigation documented the facility did not determine physical abuse occurred because there were no injuries or bruising on the resident's arms consistent with the allegation and the resident had a noted history of prejudice. According to the summary, CNA #2 was asked to return to the facility and his contract was terminated. -However, abuse occurred because CNA #2 willfully held Resident #12's arm down while CNA #3 changed the resident. B. Resident #12 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 - Few	Resident #12, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included mild cognitive impairment of uncertain or unknown etiology, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. The 10/10/24 minimum data set (MDS) assessment documented Resident #12 had moderate cognitive impairment deficits with a brief interview for mental status (BIMS) score of 12 out of 15. He did not have inattention, disorganized thinking, hallucinations or delusions. Resident #12 used a wheelchair for mobility. According the MDS assessment, Resident #12 did not have physical or verbal behavioral symptoms directed at others or rejections of care. 2. Resident observation and interview Resident #12 was interviewed on 11/18/24 at 4:09 p.m. Resident #12 said a little over a week ago, a large male CNA (CNA #2) entered his room in the middle of the night and wanted to change Resident #12's brief and bed pad. The resident told CNA #2 he was comfortable and did not want to be changed at that time. Resident #12 said CNA #2 left the room but returned with a female CNA (CNA #3) a few minutes later. He said the CNA #3 tried to forcibly remove his underwear while CNA #2 held him down by his arms. He said both CNAs left the room after he was changed. Resident #12 said he was bruised as a result of the incident. Resident #12 pointed out small red spots on both forearms/wrists and a fading purple bruise approximately the size of a quarter, on the back side of his right hand. between his thumb and index finger. He said he had reported the incident to staff on the same day as the incident. He said he had not seen CNA #3 since the incident and had heard CNA #2 was terminated. He said he had not had any concerns with other staff. Resident #12 was interviewed a second time on 11/20/24 at 1:45 p.m. Resident #12's bruise was slightly lighter in color. He said he was not fearful of anyone. 3. Record review The cognitive impairment care plan, initiated 4/14/24, identified Resident #12 had mild cognitive impairment and needed reduced distractions during interactions. The care plan was updated on 11/11/24, after the incident, to include the following interventions: -Reminding Resident #12 he was safe in his environment; -Explaining provided tasks/care in short simple sentences; -Allowing Resident #12 time to process information and respond; -Leaving the room if Resident #12 resisted a staff provided task, making sure the resident was safe and asking a different team member to approach the resident again in a timely manner; and, -Respecting Resident #12's right to decline. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The psychosocial well-being care plan, initiated 4/22/24, identified Resident #12 experienced loss of his spouse in May 2024 and loss of his home of [AGE] years. The care plan directed staff to allow Resident #12 time to answer questions and to verbalize his feelings, perceptions and fears and validating his concerns and feelings. The activity of daily living (ADL) care plan, initiated 10/7/24, directed staff to provide the resident with supportive care, assistance with mobility and encourage him to use the call light for assistance. According to the care plan, staff should allow Resident #12 sufficient time for dressing and undressing. -The review of progress notes and skin assessments prior to 11/11/24 did not not identify a bruise on Resident #12's hand. The 11/12/24 nurse progress note documented Resident #12's arms were assessed on 11/11/24 and 11/12/24 to ensure safety following the (11/11/24) occurrence investigation. The note identified a small crescent moon shaped bruise on his right hand between his thumb and first finger and red marks which were consistent with age spots. According to the note, there were no behavioral changes following the incident, the resident felt he was doing well and spent time with staff and family. The note documented staff would continue to monitor the red spots on his left arm. -The note did not identify the staff would continue to monitor the bruise on his hand. The 11/13/24 nurse progress note documented the nurse met with the resident on 11/13/24. According to the note, Resident #12 had no new bruising and the spots on the left arm continued to be consistent with age spots and there were no changes in shape or color. He continued to deny pain, there were no changes in his behavior and the resident felt he was doing well. -The note did not identify the staff would continue to monitor the bruise on his hand. The Personal Care: Dressing Dependent Resident training, conducted with staff on 5/14/24, was provided by the corporate consultant (CC) on 11/26/24 at 12:17 p.m. The training identified staff should never forcefully pull or tug on clothing to assist a resident while dressing because it could cause injury. -The review of the training did not identify CNA #2 or CNA #3 had attended the training. The Competency Fair staff training, conducted on 10/15/24 and 10/16/24, was provided by the CC on 11/26/24 at 12:17 p.m. The training reviewed facility policies, such as abuse training. -The review of the Competency Fair attendance sheet, identified CNA #2 and CNA #3 did not attend the training. The Emergency Response Plans staff signature sheet, dated between 1/16/24 and 11/21/24, and the facility's onboarding packet was provided by the DON on 11/22/24 at 9:34 a.m. The packet included the abuse policy and the resident rights policy. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident rights policy identified residents had the right to be free of verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. According to the policy, the residents had the right to make choices regarding their care, including schedules, activities, healthcare providers or health care services. -The review of the Emergency Response Plans staff signature sheet revealed CNA #2 did not sign that he had received the emergency response plans and onboarding packet. C. Staff interviews The DON was interviewed on 11/20/24 at 4:10 p.m. The DON said if there was a new bruise on a resident, staff should try to determine what was the cause of the bruise. She said staff would interview the resident and notify the physician. She said the facility would make sure the resident was safe and the bruise was not caused by another person. She said the bruise would be documented in the risk management assessment. The DON said if the cause of the bruise was not known, then she would start an investigation and interview staff. The DON said the bruise on the right hand of Resident #12 was found during a skin assessment after a reported incident on 11/11/24. The DON said Resident #12 alleged, on 11/11/24, that a staff member grabbed his arms and held him. She said the resident reported the incident to her and the lead CNA. She said the CNA (CNA #2) was an agency/travel staff member. She said CNA #2 and CNA #3 were interviewed. The DON said both CNAs said Resident #12 attempted to hit CNA #3 so CNA #2 grabbed his arm to stop him. She said CNA #2 reported he grabbed the resident's left arm. The DON said the agency CNA #2 worked for was notified and CNA #2 was suspended, pending the investigation. The DON said Resident #12 did not have a bruise on his left arm. She said the bruise on the back of his right hand was in the shape of a half moon and in between his index finger and his thumb. The DON said the bruise was not identified before the 11/11/24 incident. She said she thought the bruise might have been caused by his wheelchair. She said the bruise matched up to where he would put his hand on the wheelchair. She said she was not aware of any incidents or observations which indicated that the resident injured himself from use of his wheelchair. She said it was possible the resident's bruise was caused during the 11/11/24 incident. The DON said the facility decided not to have CNA #2 return to the facility because another resident felt the CNA was rough with care. She said the term rough could be a trigger word for potential abuse. The DON said the other residents were not fearful of CNA #2 and said he was just a little rough. The social service assistant (SSA) was interviewed on 11/21/24 at 10:07 a.m. The SSA said she assisted with abuse investigations when they were reported to her. She said she was a nurse and would conduct a head to toe assessment when needed, by use of the weekly assessment form if there was a bruise that was unexplained or an allegation of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSA said she interviewed residents anytime that there was a potential abuse allegation, including verbal and physical abuse, including a resident to resident altercation. She said if a resident was not able to answer the questions, she and the staff would make observations of their behaviors and complete an assessment for non-interviewable residents. The SSA said the social services department would report their piece of the investigation findings to the interdisciplinary team (IDT) and the NHA would make the determination if abuse was substantiated or not. The NHA was interviewed on 11/21/24 at 10:33 a.m. The NHA said she reported all allegations of abuse to the State Agency and then the social services department started the investigation with a skin assessment to check for injuries and interviews with staff. She said if a resident had a high BIMs score, they would be interviewed. She said staff should attempt to interview pertinent residents even if they had a lower BIMS score. She said if the resident was not interviewable, a non-interviewable form would be completed. The NHA said there needed to be enough information gathered to make the determination if abuse occurred. The NHA said to substantiate abuse, she needed to confirm elements of abuse occurred, such as injury and or fear, depending on what type of abuse was alleged. She said she did not determine the allegation of physical abuse towards Resident #12 was substantiated after the investigation because the resident said it was his arms that were grabbed and the bruise was found on his hand. The NHA said CNA #2 said Resident #12 kicked CNA #3 but he did not make contact with her with his hand. The NHA said Resident #12 did not indicate fear and there was no injury to his arms where he said he was grabbed. The NHA said CNA #2 was preventing the resident from striking CNA #3. She said CNA #2 was asked not to return to the facility after the incident because another resident said he was a bit rough with care. The NHA said the term rough could be a trigger word indicating potential abuse. She said the facility started an investigation when a resident alleged potential abuse. The DON was interviewed a second time on 11/21/24 at 10:54 a.m. She said CNA #2 and CNA #3 were educated by the night nurse after the incident. CNA #2 and CNA #3 were told they should have not performed ADLs after Resident #12 refused and should have informed the nurse of the refusal. The DON said both CNAs were temporary traveling staff. She said before they started working independently with the residents, they had to shadow another staff member and sign off on a packet of facility expectations and policies. She said the abuse policy was included in the packet the CNAs had to sign off on that they would have received. -However, record review revealed CNA #2 did not sign the receipt of the facility's packet that included the abuse policy. The DON was interviewed on 11/22/24 at 9:34 a.m. She confirmed CNA #2 did not sign the facility policies and expectations when he was on boarding The CC was interviewed on 11/22/24 at 12:10 p.m. The CC said the facility would make sure all temporary and current staff had reviewed and signed off on the facility policies and expectations after it was identified CNA #2 did not sign that he received the packet that included the abuse policy. The DON and the CC were interviewed together on 11/22/24 at 12:13 p.m. The CC said bruises should be monitored for 72 hours after the bruise was identified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the documentation in Resident #12's EMR did not clearly indicate the bruise to his hand was monitored. She said she recently looked at it and it was looking much better then when it was first identified on 11/11/24. The DON said Resident #12 had not made allegations towards staff before 11/11/24. The CC said restraining a resident's movement would be considered abuse. The NHA and the DON were interviewed together on 11/22/24 at 2:12 p.m. The NHA said the facility reviewed every occurrence/incident every month, including allegations of abuse and resident-to- resident altercations to identify possible trends and areas the facility needed to address. The NHA said the interdisciplinary (IDT) team tried to find the root cause of the concern, looking at what caused the incident and what could be put in place to prevent the incident from happening again. She said for resident-to-resident altercations, the team looked at interventions to help separate residents when needed and de-escalate the situation. The NHA and the DON said the facility had not looked at the lack of education provided to the temporary traveling staff. The DON said she recently requested the education the contract agency provided to the traveling staff. The DON said the facility did not have evidence that CNA #2 received and reviewed the facility's policy on abuse. The DON said, moving forward, all traveling staff were to sign the policies in person on the day of their first shift at the facility. She said the facility had created a form to verify that staff had received and understood the abuse policy going forward. 50314 III. Incident of physical abuse on 8/29/24 between Resident #52 and Resident #26 A. Facility investigation The facility's investigation of the incident on 8/29/24 between Resident #52 and Resident #26 was provided by the DON on 11/19/24 at 4:01 p.m. A statement written by CNA #4 on 9/3/24 documented Resident #52 and Resident #26 were observed attempting to elope from the Bookcliff hallway on 8/29/24 at approximately 5:45 p.m. CNA #4 said the door alarm went off and she responded in an attempt to redirect Resident #52 and Resident #26. CNA #4 said Resident #26 asked for keys to leave the facility and CNA #4 told Resident #26 she did not have them. CNA #4 said Resident #26 began yelling at her and Resident #52 told Resident #26 not to yell at CNA #4. CNA #4 said Resident #26 threatened to hit Resident #52. CNA #4 said Resident #52 put her hand on the back of Resident #26's neck and said she would like to see Resident #26 try. CNA #4 said Resident #26 then attempted to uppercut Resident #52 with only her index finger connecting to Resident #26's chin. CNA #4 said Resident #52 pushed Resident #26 and Resident #26 pushed Resident #52 back in response. CNA #4 said she was able to intervene and separate Resident #52 and Resident #26. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by the NHA on 8/29/24 documented observations of facility camera surveillance footage between 5:30 p.m. and 6:00 p.m. on 8/29/24. The observation documented that Resident #52 and Resident #26 were observed attempting to elope through the Bookcliff stairwell exit door. The statement documented that when a staff member approached the residents, Resident #52 went into her room briefly and then returned. The statement documented that Resident #26 was observed to be tapping Resident #52 on her chin. The statement documented Resident #52 then pinched or poked Resident #26 and Resident #26 poked Resident #52 in response. The statement documented neither resident was observed to stumble or fall. The investigation documentation included new recommendations for Resident #52's medication regimen to address her anxiety and restlessness. The investigation documented the facility updated care plans for Resident #26 and Resident #52. The facility documented that the attending physician, the NHA, the DON and the social services department were notified of the incident on 8/29/24 within two hours of the event occurrence. The facility documented that the police department and adult protective services were notified at 6:45 p.m. on 8/29/24. The state health department, veteran's affairs, and the ombudsman were also notified of the event on 8/29/24. The summary of the investigation documentation, not dated, was provided by the DON on 11/19/24 at 4:01 p. m. It read in pertinent part; Abuse is unsubstantiated. Element of bodily injury or unreasonable confinement or restraint not met. Element of fear not met for verbal abuse as both residents remain at baseline prior to incident. -However, CNA #4's statement documented that Resident #26 attempted to hit Resident #52 in an uppercut motion and the statement further documented Resident #26 and Resident #52 pushed each other. -Furthermore, the NHA documented she observed via the camera footage, that Resident #26 intended to hit Resident #52 with her hand and the NHA documented Resident #52 and Resident #26 pinched and poked each other (see NHA statement above and interview below). B. Resident #52 1. Resident status Resident #52, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia, unspecified mood disorder and unspecified depression. The 9/12/24 MDS assessment documented the resident was severely cognitively impaired with a BIMS score of five out of 15. The resident required moderate assistance with oral hygiene, dressing and toileting hygiene. The assessment documented Resident #52 was independent with all other aspects of daily mobility. The assessment documented that Resident #52 exhibited wandering behaviors on a daily basis which put her at a significant risk for her to get to a potentially dangerous place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment documented that Resident #52 had exhibited physical and verbal behavioral symptoms directed towards others on one to three days during the assessment period. The assessment documented Resident #52's physical and verbal behaviors created a significant risk of causing herself physical illness or injury, significantly interfered with her care and put others at significant risk for physical injury, intruded on the safety or privacy of others and disrupted the care environment. The assessment documented that Resident #52's behaviors were getting worse. 2. Resident #52's representative interview Resident #52's representative was interviewed on 11/20/24 at 10:07 a.m. The representative said Resident #52 had severe dementia and elopement behaviors. The resident's representative said he thought Resident #52 and Resident #26 were friends. He said he had seen Resident #52 and Resident #26 arguing in the dining room, however, Resident #52 was known to argue with others around her for years even before she received her dementia diagnosis. The resident's representative said he was notified that Resident #52 and Resident #26 hit each other on 8/29/24 after trying to elope from the facility together. He said Resident #52 was not known to be physically aggressive before the event on 8/29/24. 3. Record review The elopement plan of care, initiated and revised 9/3/24, documented that Resident #52 was a high elopement risk because of her cognitive deficits. The plan of care documented the goal was for Resident #52 to be at a reduced risk of injury and elopement through the review period. The plan of care documented interventions including redirecting Resident #52 to other activities of interest when she was wandering, to keep Resident #52 within line of sight of staff members when outside of her room and to reassure Resident #52 that the animals were fed and her kids were safe. A social services quarterly note, dated 10/2/24, documented that Resident #52 was a high elopement risk and the resident needed to be within staff line of sight when outside her room. A behavior monitoring note, signed 8/30/24 by LPN #4, documented that Resident #52 and Resident #26 were observed attempting to elope on 8/29/24 after dinner. The note documented that Resident #52 punched Resident #26 in her neck. It documented that immediately thereafter, both residents were separated and placed on frequent checks. C. Resident #26 1. Resident status Resident #26, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia, unspecified depression and anemia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/22/24 significant change MDS assessment documented Resident #26 was severely cognitively impaired with a BIMS score of six out of 15. The resident required supervision with upper body dressing and oral hygiene and moderate assistance with personal hygiene. The assessment documented that Resident #26 was independent walking 50 feet, but required a helper to provide verbal cues when walking 150 feet. The assessment documented Resident #26 was independent with all other aspects of daily mobility. The assessment indicated Resident #26 experienced hallucinations and delusions but did not exhibit physical or behaviors directed towards herself or others. The assessment documented that Resident #26 exhibited wandering behaviors on one to three days during the assessment period, but the wandering behavior did not place the resident at risk of getting to a potentially dangerous place. 2. Record review The elopement plan of care, initiated 5/2/24 and revised 7/12/24, documented that Resident #26 was at a high risk of elopement because the resident would often be looking for her husband and children, and experienced increased confusion. The facility documented her elopement plan of care goal was to keep her safe through the current review period. The facility documented interventions included keeping Resident #26 within line of sight when she went upstairs to the office or visited with other residents, to offer distractions to decrease wandering behaviors, and to reassure the resident that her family was fine because Resident #26 was often confused about where she was at. A social services quarterly assessment, dated 7/17/24, documented Resident #26 did not have a history of wandering behaviors. The assessment documented Resident #26 did not have elopement precautions and Resident #26 was not at risk for elopement. -The social services quarterly assessment failed to accurately document Resident #26's wandering behaviors. An elopement assessment, dated 11/12/24, documented that Resident #26 had no history of wandering behaviors. The assessment documented Resident #26 was a moderate risk for elopement. -The elopement assessment failed to document the elopement behaviors witnessed by the facility staff on 8/29/24. D. Staff interviews Registered nurse (RN) #1 was interviewed on 11/20/21 at 9:51 a.m. RN #1 said Resident #26 and Resident #52 were both known to wander in the facility, but it was usually rare for Resident #26 to wander while it was often a daily occurrence for Resident #52 to wander. RN #1 said Resident #52 was known to help other residents and the resident would wander around to look for other residents who needed help. RN #1 said Resident #52 was easily redirected when she was observed to be wandering where she was not supposed to be. RN #1 said she had heard Resident #52 and Resident #26 hit each other a few months ago. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing assistant (NA) #2 was interviewed on 11/21/24 at 10:41 a.m. NA #2 said she was present in the building on 8/29/24. NA #2 said at the time, she was in the role of a student observer on the upstairs floor. NA #2 said she was not interviewed as part of the investigation between Resident #52 and Resident #26. NA #2 said she did not see anything occur that day since she was on the second floor and the event occurred on the first floor of the building. NA #2 said Resident #52 was known to wander in other resident rooms and all nursing staff knew to look out for her whenever she was moving in the building to ensure she was not going somewhere she was not supposed to. RN #2 was interviewed on 11/21/24 at 3:21 p.m. RN #2 said she heard Resident #52 and Resident #26 hit each other several months ago while trying to elope through the stairwell door. RN #2 said she was not working in the building on 8/29/24. RN #2 said when she worked downstairs she kept a close eye on both residents. RN #2 said she had not observed either Resident #52 or Resident #26 exhibit aggressive behaviors in September 2024, October 2024 or November 2024. RN #2 said care staff had to redirect Resident #52 from her wandering behaviors on a daily basis. RN #2 said she had observed Resident #26 exhibit wandering behaviors on only one occasion in the last few months. The NHA was interviewed on 11/22/24 at 11:32 a.m. The NHA said she reviewed the camera footage of the physical altercation that occurred between Resident #52 and Resident #26 on 8/29/24 but said she did not witness the original event occur. The NHA said the camera footage revealed Resident #52 approached Resident #26 from behind and placed her open hand on the back of Resident #26's neck. The NHA said she then Resident #26 brushed the chin of Resident #52. The

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure resident choices for one (#213) of two residents reviewed for activities of daily living (ADL) out of 40 sample residents. Specifically, the facility failed to provide bathing assistance for Resident #213 per her preference. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) policy, revised 6/6/24, was received from the corporate consultant (CC) on 11/22/24 at 1:33 p.m. It documented in pertinent part, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. II. Resident #213 A. Resident status Resident #213, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician order (CPO), diagnoses included paraplegia (loss of function in the lower legs), congestive heart failure,and generalized muscle weakness. According to the 11/14/24 minimum data set (MDS) assessment Resident #213 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment documented Resident #213 was dependent on staff for toileting, hygiene, dressing, chair and toilet transfers. The assessment did not document the amount of assistance Resident #213 needed with bathing. B. Resident interview and observations Resident #213 was interviewed on 11/19/24 at 9:35 a.m. Resident #213 said she was admitted to the facility earlier in the month and had only received one bed bath since her admission on 11/7/24. Resident #213 said she hoped to receive two baths per week. Resident #213 said she was paraplegic and had no feeling below the level of her waist. Resident #213 said that she knew her care took more time and staff, since she was unable to move or control the lower half of her body. Resident #213 said she could not sense if the lower half of her body was not clean. Resident #213 said her hair was difficult to comb because it had not been washed recently. Resident #213 said she felt sad that she required extensive assistance with bathing because she perceived her extensive ADL care needs would reduce the help other residents received on her bath days. Resident #213's hair was greasy. She was attempting to comb through it, but was struggling to do so. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 9:12 a.m., the restorative registered nurse (RRN) was discussing the daily plan to get Resident #213 out of bed and into the wheelchair with another unidentified staff member. The RRN said Resident #213 required three person assistance with a hoyer lift to get her out of bed and into the wheelchair. III. Record review The ADL/mobility plan of care, initiated on 11/15/24 and revised on 11/15/24. The plan of care documented Bathing/Showering level of assistance: Independent; set-up assistance; supervision; minimal assist; extensive assist; dependent. -A review of the resident's comprehensive care plan did not reveal documentation indicating Resident #213's bathing preferences or the level of assistance Resident #213 required with bathing. The Bathing/shower preference documentation was reviewed between 11/7/24 and 11/21/24. The facility documented Resident #213 was unavailable for bathing preference discussions on 11/18/24 and bathing preference discussions were not applicable on 11/8/24, 11/11/24 and 11/15/24 (see interviews below). The facility point of care bathing documentation was reviewed for 14 days (11/7/24 to 11/21/24). It documented Resident #213 had received two baths out of four opportunities. IV. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 11/21/24 at 1:41 p.m. CNA #3 said it was normal for residents to receive two baths per week or by the resident's preference. CNA #3 said if a resident refused a bath the nurse would be told and the resident refusal would be documented in the electronic medical record (EMR). Registered nurse (RN) #2 was interviewed on 11/21/24 at 1:55 p.m. RN #2 said the residents received two baths per week on their chosen days unless the resident had a more specific preference. RN #2 said it was important to bathe residents to reduce infection risk and also because it felt nice to be clean. The director of nursing (DON) was interviewed on 11/22/24 at 10:27 a.m. The DON said she reviewed Resident #213's bathing documentation between 11/7/24 and 11/21/24. The DON said Resident #213 received two baths in the review period. The DON said Resident #213 did not receive enough baths. The DON said the residents should receive two baths per week or by their stated preference. The DON said Resident #213's bathing preference and assessment documentation did not make sense and should not have been documented as not applicable.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to provide care and treatment to prevent the development and worsening of pressure injuries for one (#54) of two residents reviewed for pressure injuries out of 41 sample residents. Resident #54 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, history of toe amputation, osteomyelitis (bone infection) and neuropathy. On 9/26/24, after not wearing her podiatry ordered offloading boots due to a red area on her heel, potentially from the podiatry offloading boot and/or a screw located on her wheelchair foot pedal, Resident #54 developed a blister on her left heel which progressed into an unstageable pressure ulcer. Resident #54 had physician's orders for the offloading pressure relieving boots and the boots were care planned, however, the resident did not consistently wear the boots as ordered. The resident's refusals to wear the boots were not documented or refusals were not care planned and there were no care plan interventions directing staff what to do if the resident refused the boots. Resident #54 was able to identify why she did not consistently wear the pressure relieving boots but the facility did not ask the resident her reasoning or implement interventions to address the resident's concerns with the pressure relieving boots. Due to the facility's failures to ensure effective interventions were put in place and monitored for compliance and effectiveness, Resident #54 developed a blister to her left heel which worsened to an unstageable pressure ulcer. Additionally, Resident #54 was identified on 11/13/24 to have a potential second pressure wound developing to her right lateral foot. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com on 12/3/24, Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with non blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Category/Stage 2: Partial Thickness Skin Loss. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. The Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss. Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcer can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar tan, brown or black) on the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth,and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed. Suspected Deep Tissue Injury: Depth Unknown. Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Wound Management policy, revised on 8/7/24, was provided by the corporate consultant (CC) on 11/22/24 at 10:02 a.m. The policy read in pertinent part, To promote wound healing and decrease the risk of developing various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and provider orders. Wound treatment should be provided in accordance with provider orders, including the cleansing method, type of dressing and frequency of dressing change. Implement appropriate interventions to decrease risk of recurrence as applicable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatments should be documented on the MAR (medication administration record) or TAR (treatment administration record). The effectiveness of treatments should be monitored through ongoing assessment of the wound. The resident's comprehensive care plan should be kept up to date. III. Resident #54 A. Resident status Resident #54, age greater than age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included diabetes mellitus due to underlining condition with diabetic autonomic (complication of diabetes), acute kidney failure, osteomyelitis (bone infection), unspecified open wound of unspecified toe and other abnormalities of gait and mobility. The 10/11/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident did not exhibit rejection of care behaviors and used a wheelchair for mobility. According to the MDS assessment, the resident was at risk for developing pressure ulcers and had an unhealed stage one or greater pressure ulcer. The MDS assessment revealed the resident had an unstageable pressure ulcer. IV. Resident interview and observations Resident #54 was interviewed on 11/18/24 at 3:48 p.m. Resident #54 was sitting in a wheelchair in her room. She said she developed a blister on her left foot that turned into a wound. She said she did not have a lot of feeling in her foot but the boot she received (from the podiatry physician) had bothered her foot. The resident said she developed the blister shortly after being admitted to the facility. Resident #54 said she had a boot she should have been wearing but she had not put it on for the day (11/18/24). She said she was supposed to wear the boot when she was up and out of bed. She said she could put the boot on herself but staff could help her if she asked them too. Resident #54 said she should currently be wearing the soft form heel protective boot for her left foot, but the boot would get tangled up in her wheelchair and so she did not like to wear it. On 11/20/24 at 10:04 a.m. Resident #54 was laying in bed. The resident wore socks on her feet, however she was not wearing her heel protective boots. Resident #54's heels were resting directly on the bed. Resident #54 was interviewed a second time on 11/20/24 at 1:54 p.m. Resident #54 was in her wheelchair and wore a heel protective boot on her left foot. The resident's feet were both on the wheelchair foot pedals. She said she just got back from a podiatry appointment and said the wound on her left foot would be slow to heal. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/21/24 at 8:42 p.m. the resident was in bed. She had two soft foam heel protective boots by her walker which she was not wearing. On 11/22/24 at 9:03 a.m. Resident #54 was sitting on her bed. She did not have her heel protective boots on. The resident said she did not like wearing boots in bed because she needed a pillow between her knees for comfort, and the pillow and the boots were too much together. Resident #54 said her soft form boots were too bulky to wear in bed and with her wheelchair. She said her wheelchair foot pedals were not comfortable with the boots on. She said there was a screw that held the back strap on the foot pedal that was causing some rubbing on her foot. She said the screw was removed but the foot pedals, the size of her wheelchair and the boots together did not feel comfortable. She said no one had looked at her foot pedals or her wheelchair to determine if there could be an adjustment made to create a better fit when she wore her foam heel protective boots. V. Wound care observations and interview On 11/20/24 at 1:40 p.m. wound care was observed with the physician (PHY). Resident #54 wore a heel protective boot over a sock on her left foot. The PHY said the wound to her left foot was started by a podiatry shoe. He said the shoe caused a blister so the resident stopped using the shoe. The PHY said the podiatry shoe had a plastic insert in the heel that could not be removed and that caused the pressure to the resident's heel. The PHY said the facility had had difficulty with the local podiatry specialists and had had to watch their recommendations and devices closely over the last few months. Resident #54's left heel had eschar (dead tissue) throughout the wound. The wound measured 3.5 centimeters (cm) by 4.2 cm x 0.1 cm. The PHY said the wound was unstageable. The PHY said the wound was avoidable because of the shoe from the podiatrist, but was also unavoidable because her blood sugars were out of control when the injury occurred. The PHY placed Iodosorb (wound treatment) around the edges of eschar and a large heel dressing was placed on the resident's heel. A sock and a blue heel protective boot were placed on the resident's left foot. VI. Record review The 7/18/24 Braden Scale assessment (a tool for predicting pressure ulcer risk) identified Resident #54 was at risk for developing pressure sores The skin integrity care plan, revised 11/7/24, indicated Resident #54 had a potential/actual impairment to skin integrity to her bilateral feet related to diabetes type 2 neuropathy, fragile skin and a current chronic non healing wound. The care plan identified the resident had a recent surgical toe amputation and a history of osteomyelitis and cellulitis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The care plan interventions on 7/22/24 included directing staff to document weekly treatment to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, educating the resident/family/caregivers of causative factors and measures to prevent skin injury, encouraging good nutrition and hydration in order to promote healthier skin, following facility protocols for treatment of injury, identifying and documenting potential causative factors and eliminating/resolving where possible, monitoring/documenting location, size and treatment of skin injury and reporting abnormalities, failure to heal and signs and symptoms of an infection or maceration to the physician. The care plan interventions initiated on 10/21/24 included using caution during transfers and bed mobility to prevent striking the resident's arms, legs, and hands against any sharp or hard surface, using bilateral foot pedals on the resident's wheelchair for offloading and using offloading boots when the resident was seated and lying down. -Review of Resident #54's care plan did not identify the resident refused her offloading heel protective boots. -The care plan did not identify interventions to try if and when the resident refused to wear her heel protective boots. The skin/wound note, dated 9/26/24 at 6:17 p.m. documented Resident #54 informed the registered nurse (RN) there was an issue with her left foot. The RN assessed the resident's foot and identified the resident had a large blister covering the majority of the edge of her heel. According to the note, the blister was not present earlier during the shift when the RN changed the dressing to the resident's hallux (toe) on the same foot. The note identified the resident was not wearing her heel protective boot on 9/26/24 by choice. The RN notified the wound care nurse (WCN). A second skin/wound note, dated 9/26/24 at 9:31 p.m. documented Resident #54 had a large 3 cm by 2 cm serous (clear, liquid part of the blood) filled blister. The blister was drained and treated per the recommendations of the PHY. Resident #54 was unsure of how the blister formed but said she had noticed a red area on her left heel prior to the formation of the blister. The note identified the lack of the resident not wearing her boot could have contributed to the blister. The resident said the bottom area of the blister was sore but the pain was relieved once drained. The podiatry report dated 10/2/24 documented Resident #54 had a blister on her left heel. The resident had been using a wheelchair which had a screw on it and the resident believed the blister began due to the rubbing of the screw and the boot she was wearing had a hard area inside it. The blister had increased in size from the size of a quarter to a half dollar. The podiatry note further documented Resident #54 developed a blister on the left heel likely due to pressure from a screw on the wheelchair and from a hard boot. The blister had been drained and dressed regularly. The wound was not deep but continued wound care was necessary to prevent it from becoming deeper. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The physician note dated 10/2/24 identified Resident #54 had a deep tissue pressure injury persistent and non blanchable pressure injury acquired on 10/2/24. The initial wound measured 4.5 cm width by 0.2 cm depth with a small amount of serous drainage. The physician recommended offloading and floating the resident's heels in bed and directed staff to check on the resident's feet and lower extremities every shift and ensure proper footwear. Review of the November 2024 CPO revealed the following physician's orders: Use of offloading boots (heel protective boots), ordered on 10/21/24. Wound care: change the left inner heel dressing daily. Cleanse with wound cleanser soaked gauze, remove and allow it to dry. Apply Iodosorb around the wound edges, cover with foam heel dressing and notify the provider and/or wound RN of concerns, ordered on 10/23/24. -The October 2024 medication administration record (MAR) and the treatment administration record (TAR) did not identify the active order for the use of heel protective boots. -The October 2024 MAR and TAR did not identify the tracked administration and use of the ordered heel protection. -Review of Resident #54's October 2024 electronic medical record (EMR) did not identify Resident #54 was offered and refused the physician ordered heel protective boots. The skin/wound note dated 11/6/24 documented the resident's left inner heel wound was an unstageable pressure wound measuring 3 cm by 3 cm by 0 cm. The 11/9/24 podiatry consultation report documented Resident #54 had a podiatry appointment on 11/20/24 at 11:00 a.m. The report identified Resident #54 should wear offloaders (heel protective boots) to both feet when she was not ambulating. -However, observations during the survey revealed Resident #54 was not consistently wearing her heel protective boots (see observations above). The skin/wound note, dated 11/13/24, identified the resident's right lateral foot was red but the skin was intact. The right foot would be monitored daily during wound care to the left foot and staff was to place a foam dressing if necessary and notify podiatry at the 11/20/24 appointment per the PHY. According to the wound note, the resident should be encouraged to wear foam heel protective boots for increased protection and offloading. -However, observations during the survey revealed Resident #54 was not consistently wearing her heel protective boots (see observations above). The note further documented Resident #54 left inner heel dressing was removed revealing an increased maceration (breakdown of the skin due to prolonged exposure to moisture) to 360 degrees surrounding the wound's edges due to the dressing not covering the entire site of the wound. The wound measured 3.3 cm by 4.2 cm by 0.3 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The podiatry report, dated 11/20/24, identified Resident #54 was seen by the podiatrist on 11/20/24. The report documented the resident reported her heel dressing was changed daily, however the dressing had not been changed before the 11/20/24 (at 11:00 a.m.) appointment. The report identified the resident's left medial heel had eschar measuring 4 cm by 3 cm with a small amount of drainage at the wound edges. According to the report, the resident did not have an offloading heel protective boot and an offloading heel boot was provided to the resident to relieve pressure. In addition, the podiatry report identified Resident #54 had a stage 0 pressure ulcer at the base of her right fifth metatarsal (a bone in the foot). The skin/wound note, dated 11/20/24, documented the resident returned from her podiatry appointment. The left heel wound measured 1.5 cm by 1 cm by 0.5 cm with 100% dry stable eschar to the wound site without drainage or odor. According to the note, the resident was to wear offloading heel protective boots to bilateral feet when she was not ambulating. -However, observations during the survey revealed Resident #54 was not consistently wearing her heel protective boots (see observations above). -The November 2024 MAR and TAR did not identify the active order for the use of heel protective boots. -The November 2024 MAR and TAR did not identify the tracked administration and use of the ordered heel protection. -Review of Resident #54's November 2024 EMR did not identify Resident #54 was offered and refused the physician ordered heel protective boots. VII. Staff interviews The WCN and the DON were interviewed together on 11/21/24 at 1:20 p.m. The WCN said Resident #54 had an unstageable pressure ulcer to her left inner heel. The WCN said on 9/26/24, Resident #54's nurse notified her that the resident had a serous filled blister on her left heel. She said the resident wore an offloading boot she received from the podiatrist as ordered on 8/1/24. The WCN said the resident told the nurse the offloading boot was giving her a red mark so she did not wear the boot on 9/26/24, potentially resulting in the blister to her heel. The WCN said the resident had been wearing the boot since shortly after her facility admission (7/18/24). She said Resident #54 had not complained of the boot bothering her before 9/26/24 and a red mark was not observed on her heel. She said the offloading boot the podiatrist provided had a piece of plastic near the heel of the boot as part of its design. She said Resident #54 went to the podiatrist after the blister developed and was provided with the soft foam heel protective boots. The WCN said Resident #54 should have been wearing the heel protective boots all the time unless she was transferring from surface to surface. She said the staff should be reminding and encouraging the resident to wear the soft foam heel protective boots to both of her feet and use her wheelchair foot pedals when she was using her wheelchair. The WCN said the staff should be documenting any refusals of the heel protective boots in the MAR and TAR. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The WCN said she had not care planned that Resident #54 did not consistently use and/or refused her physician ordered heel protective boots. The WCN said the resident did not feel and or understand that she should be wearing the heel protective boot of her right foot for pressure relief along with the left foot. She said she had not care planned that the resident did not want to use the right boot either. The WCN said Resident #54 felt she only needed the boot worn on her left foot to cover the wound. The WCN said she had not care planned interventions regarding what staff should do when the resident refused the heel protective boots. The DON said she had seen Resident #54 wear the left heel protective boot but not the right. She said she had not asked the resident why she did not wear the boots consistently. The WCN said the soft foam heel protective boots were bulky but she was not aware the resident felt the boot got tangled up with her wheelchair. The WCN said the resident told her the boots were uncomfortable in bed so she suggested Resident #54 try to prop a pillow under her legs, but she said she needed to evaluate if the pillow would be comfortable to her as an intervention. The WCN said Resident #54 was at risk for additional concerns because she had lost a toe (related to osteomyelitis) and did not want the same concern to happen to her foot. Certified nurse aide (CNA) #6 was interviewed on 11/22/24 at 9:15 a.m. CNA #6 said he frequently worked with Resident #54. He said he usually saw Resident #54 wearing a heel protective boot on her left foot when she was out of her room. He said she could put the boot on herself. He said the resident did not need or use a heel protective boot on her right foot. He said she only needed a heel protective boot to cover the left foot wound. CNA #6 said he was not sure if the resident should wear the heel protective boots in bed. -However, the resident had a physician's order to wear the heel protective boots and instructions from the physician to wear them except when she was ambulating (see record review above) The DON and the NHA were interviewed together on 11/22/24 at 2:12 p.m. The DON said pressure ulcers were reviewed with the IDT. She said the team reviewed the residents that currently had pressure ulcers, identified if the pressure ulcers were improving, what treatments were provided and received insight from the medical director. The DON said the staff spoke to Resident #54 on 11/21/24 (during the survey) and learned that the resident did not always wear her foot pedals as she should and the facility would be following up with her on her concerns with the foot pedals. The DON said the facility needed to work on improving documenting refusals of interventions, increasing observations of the resident and addressing concerns with the resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible, and that each resident received adequate supervision and assistive devices to prevent accidents. This failure affected one discharged resident (#61) and 22 current residents (#34, #31, #22, #14, #46, #35, #2, #33, #45, #17, #21, #42, #47, #54, #4, #7, #58, #18, #43, #52, #40 and #29) out of 41 sample residents. Specifically: TRANSFER POLES On [DATE], Resident #61, severely cognitively impaired and with a history of falls, was discovered stuck between the bed and his transfer pole. The facility failed to complete a safety risk assessment for Resident #61 before placing the transfer pole and, after the incident on [DATE], failed to investigate how the resident got stuck between the transfer pole and his bed. Record review and interviews revealed the facility failed to complete safety risk assessments for all 17 current residents (#34, #31, #22, #14, #46, #35, #2, #33, #45, #17, #21, #42, #47, #54, #4, #7 and #58) who had a transfer pole, to ensure resident safety. These failures created a situation of immediate jeopardy for serious harm that required immediate corrective action. FALLS The facility failed to prevent multiple falls, complete assessments after falls, investigate falls, and timely update fall care plans for Resident #18, Resident #43, Resident #52, Resident #4, and Resident #40. SMOKING and OXYGEN The facility failed to ensure Resident #29 did not smoke with his oxygen cannula on his face and hunched over his portable oxygen tank. Findings include: I. IMMEDIATE JEOPARDY A. Situation of Immediate Jeopardy Resident #61 was admitted on [DATE] with a history of falling. The resident was identified as severely cognitively impaired. The resident was ordered a vertical transfer pole to help with self-transfers on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to complete a safety risk evaluation for the use of the vertical transfer pole. On [DATE], Resident #61 was discovered by a certified nurse aide (CNA) stuck between the transfer pole and his bed. The CNA triggered the resident's emergency call light because she was unable to reposition the resident without assistance. The nurse responded and found the CNA trying to remove the resident from between the transfer pole and bed. The nurse noted the resident displayed agonal breathing (gasping), his eyes were open but he was not blinking and he had no pulse. The CNA and nurse repositioned the resident on his bed and did not start cardiopulmonary resuscitation (CPR) because the resident had an order for do not resuscitate. The nurse applied oxygen and emergency medical services (EMS) was called. When EMS arrived, the resident had begun breathing on his own. The facility failed to complete a safety risk assessment for Resident #61 after the incident on [DATE]. On [DATE], the facility completed a physical restraint assessment; however, the restraint assessment did not include a safety assessment. On [DATE] at 7:20 p.m., the nursing home administrator (NHA) was notified the failure in the facility's response to the incident on [DATE] and the failure to conduct safety risk assessments for all of the 17 current residents with transfer poles created a situation of immediate jeopardy that required immediate corrective action. B. Plan to remove Immediate Jeopardy On [DATE] at 6:05 p.m., the facility submitted the following plan to remove the immediate jeopardy situation: On [DATE] physical therapy (PT) staff completed evaluations for each resident with access to a transfer pole. Evaluations included proper placement (bed height, proximity to wall and/or toilet, distance from transfer surface) as well as resident conditions that may affect transfer, any risks for entrapment for all residents with access to transfer pole i.e. shared bathrooms. Assessments included: General assessment: fall risk, cognition, transfer ability and other comorbidities that may affect ability to safely use assistive or transfer devices by PT; Bedside: to include transfer ability with multiple assistive devices to determine safest option for individual resident need. PT to establish the distance from bed to appropriate assistive device and determine safest distance based on individuality of the resident and manufacturer's recommended use to 'make sure the product has sufficient space to allow user(s) to walk between the pole or handle and any other stationary object.' Assessment will include mechanics of the bed, including possible mattress and wheel shift; Placement considered safe and appropriate by PT from beside and bathroom individual evaluation as evidenced by distance deemed safe and beneficial through multiple transfer trials with PT to determine the resident's specific body habitus. 15-minute checks performed by direct care staff on shift until evaluation or assessment is completed by therapy and further determination is made. Evaluation or assessment to be completed by the end of business day [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Education of nursing staff will be provided by director of nursing (DON), infection preventionist (IP) or lead CNA prior to staff's next scheduled shift. Lead CNA educated by DON. Education includes: 15-minute checks and resident safety for residents for increased fall risk and for the residents that still have access to a transfer pole. If a new transfer or assistive device is implemented, the above staff will continue to educate front line staff, housekeeping and maintenance. Beds will be marked and staff educated to ensure appropriate placement. Will monitor placement of device installed in relation to the mattress, if the device is at bedside, an order obtained from PT every shift by nursing, daily safety rounds by restorative and quarterly by therapy and as needed. Resident's bed and any furniture in close proximity to the device will be marked on the floor to ensure proper replacement of furniture should it need to be temporarily moved. Will continue to encourage call light use. For those residents whose transfer pole was removed, staff have been educated to provide 15-minute checks, offer transfer assistance and encourage call light use education provided to direct care staff to continue with 15-minute checks until the interdisciplinary team (IDT) determines they are no longer needed to ensure safety. Encourage residents to use call light to request assistance and staff to provide transfer assistance as indicated. Any new transfer pole request will not be ordered or initiated until therapy completes and evaluation to determine appropriateness. C. Removal of Immediate Jeopardy Based on a review of the facility's plan, observations, and record review, the NHA was informed the immediate jeopardy situation was removed on [DATE] at 6:05 p.m. However, the deficient practice remained at a G level, isolated, actual harm. II. TRANSFER POLES A. Resident #61 1. Resident status Resident #61, age greater than 65, was admitted on [DATE] and passed away on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included heart failure, abdominal aortic aneurysm without rupture (swelling in the artery in the stomach), chronic kidney disease, osteoarthritis of the left knee, and abnormalities of gait and mobility. The [DATE] minimum data set (MDS) assessment revealed Resident #61 had a severe cognitive impairment with a brief interview of mental status (BIMS) score of three out of 15. Resident #61 was documented to have an impairment to both lower extremities and used a wheelchair. The resident had no restraint devices documented. 2. Record review Resident #61's activities of daily living (ADLs) care plan documented a vertical transfer pole as an intervention on [DATE]. Resident #61 had a physician's order for a vertical transfer pole dated [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], a progress note documented in Resident #61's electronic health record (EHR) revealed: -At approximately 12:45 p.m., the nurse responded to the resident's emergency call light. The nurse discovered the CNA was attempting to remove the resident from in between the transfer pole, his bed, and a chair where the resident appeared to be stuck. The resident was noted to be bent over in a crumpled-up position with his foot stuck in between the transfer pole and his bed. -The resident was unresponsive with agonal breathing and his eyes were open and not blinking. The nurse attempted to assist the CNA by keeping the resident upright while two other CNAs moved the bed to free the resident's foot. The staff moved the resident flat on his bed into a Trendelenburg position (feet placed higher than the resident's head). -Resident #61 was not responding to verbal stimuli or a sternal rub. The nurse was unable to feel the resident's pulse. The nurse sent a CNA to get the physician and another CNA to call 911 and check the resident's code status. The resident was a do not resuscitate (DNR) and CPR (cardiopulmonary resuscitation) was not provided. The physician verified there was a cessation of heartbeat during the assessment of the resident. EMS arrived and Resident #61 began breathing more at a regular rate within several minutes of being in Trendelenburg and applying oxygen. The resident was making nonsensical statements. When EMS arrived the resident was able to speak and a transfer to the hospital was not necessary. A review of the resident's record revealed no evidence the facility had completed a safety risk assessment for Resident #61 before placing the transfer pole and, after the incident on [DATE], no evidence the facility completed a safety risk assessment or investigated how the resident became stuck between the transfer pole and his bed. On [DATE], a physical restraint evaluation was completed for Resident #61 and the transfer pole. However, the evaluation did not include a safety risk assessment. In addition to the failures above for Resident #61, the facility failed to review the use of transfer poles by 17 current facility residents (see below). B. Resident #34 1. Resident status Resident #34, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included osteoarthritis in an unspecified hand, fibromyalgia, dementia, pain in the right hip, generalized muscle weakness, and lack of coordination. The [DATE] MDS assessment revealed Resident #34 had a severe cognitive impairment with a BIMS score of six out of 15. Resident #34 used a walker and a wheelchair. The resident had no restraint devices documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #34 had a vertical transfer pole next to her bed. 3. Record review (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #34 did not have a physician's order for a vertical transfer pole. Resident #34 did not have documentation in her care plan for a vertical transfer pole. Resident #34 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #34 was a high fall risk. C. Resident #31 1. Resident status Resident #31, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic kidney disease, mild cognitive impairment, and Guillain-Barre Syndrome (a neurological disorder where the nervous system attacks the peripheral nervous system). The [DATE] MDS assessment revealed Resident #31 had a severe cognitive impairment with a BIMS score of six out of 15. Resident #31 had no impairments to his extremities and used a cane or crutch to walk. The resident had no restraint devices documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #31 had a vertical transfer pole next to his bed. 3. Record review Resident #31 did not have a physician's order for a vertical transfer pole. Resident #31 did not have documentation in his care plan for a vertical transfer pole. Resident #31 did not have a safety risk assessment for a vertical transfer pole A fall risk assessment completed on [DATE] revealed Resident #31 was a high fall risk. D. Resident #22 1. Resident status Resident #22, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included seizures, epilepsy, traumatic brain injury with loss of consciousness, macular degeneration (a disease that damages the eye), and mild cognitive impairment. The [DATE] MDS assessment revealed Resident #22 had a severe cognitive impairment with a BIMS score of six out of 15. Resident #22 had no impairments to his extremities and used a wheelchair. The resident had a motion sensor alarm used daily but no other restraints were documented. 2. Observations (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at approximately 2:00 p.m., observations revealed Resident #22 had a vertical transfer pole next to his bed. 3. Record review Resident #22 did not have a physician's order for a vertical transfer pole. Resident #22 did not have documentation in his care plan for a vertical transfer pole. Resident #22 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #22 was a high fall risk. E. Resident #14 1. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included psychotic disorder with delusions, osteoarthritis, age-related macular degeneration, dementia, and Parkinson's disease. The [DATE] MDS assessment revealed Resident #14 was unable to participate in the assessment because he was unable to be understood. The staff assessment revealed the resident had short-term and long-term memory problems. Resident #14 had an impairment to his lower extremities and used a walker and wheelchair. The resident had no restraint devices documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #14 had a vertical transfer pole next to his bed. 3. Record review Resident #14 did not have a physician's order for a vertical transfer pole until [DATE] (during the survey). Resident #14 did not have documentation in his care plan for a vertical transfer pole until [DATE] (during the survey). Resident #14 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #14 was a high fall risk. F. Resident #46 1. Resident status (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #46, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included bipolar disorder, abnormalities of gait and mobility, abnormal involuntary movements, and neuroleptic-induced Parkinsonism (Parkinson's disease caused by antipsychotic medications). The [DATE] MDS assessment revealed Resident #46 had a moderate cognitive impairment with a BIMS score of nine out of 15. Resident #46 had impairments to his lower extremities and used a walker and a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #46 had a vertical transfer pole next to their bed. 3. Record review Resident #46 had a physician's order for a vertical transfer pole on [DATE]. Resident #46 did not have documentation in his care plan for a vertical transfer pole. Resident #46 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #46 was a high fall risk. G. Resident #35 1. Resident status Resident #35, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included dementia, stage three chronic kidney disease, osteoarthritis, and bilateral low-tension glaucoma. The [DATE] MDS assessment revealed Resident #35 had a severe cognitive impairment with a BIMS score of five out of 15. Resident #35 had impairments to one side of his lower extremities and used a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #35 had a vertical transfer pole next to his bed. 3. Record review Resident #35 did not have a physician's order for a vertical transfer pole. Resident #35's fall care plan revealed the resident had a transfer pole as a fall intervention on [DATE]. Resident #35 did not have a safety risk assessment for a vertical transfer pole. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A fall risk assessment completed on [DATE] revealed Resident #35 was a high fall risk. H. Resident #2 1. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included altered mental status, repeated falls, bilateral primary osteoarthritis of the knee, Parkinson's disease with dyskinesia (involuntary movements), Parkinson's disease without dyskinesia, bilateral age-related nuclear cataract (an eye disease that causes blindness) and muscle wasting and atrophy. The [DATE] MDS assessment revealed Resident #2 was cognitively intact with a BIMS score of 15 out of 15. Resident #2 had impairments to his lower extremities and used a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #2 had a vertical transfer pole next to his bed. 3. Record review Resident #2 did not have a physician's order for a vertical transfer pole. Resident #2 did not have documentation in his care plan for a vertical transfer pole. Resident #2 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #2 was a high fall risk. I. Resident #33 1. Resident status Resident #33, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included stage two chronic kidney disease, peripheral vascular (eye) disease, restless legs syndrome, and cellulitis (infection) in her lower extremities. The [DATE] MDS assessment revealed Resident #33 was cognitively intact with a BIMS score of 15 out of 15. Resident #33 had impairments to her lower extremities and used a walker and a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #33 had a vertical transfer pole next to her bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review Resident #33 did not have a physician's order for a vertical transfer pole. Resident #33 did not have documentation in her care plan for a vertical transfer pole. Resident #33 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment was not completed for Resident #33. However, Resident #33's fall care plan revealed she was a moderate risk for falls. J. Resident #45 1. Resident status Resident #45, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic kidney disease and osteoarthritis. The [DATE] MDS assessment revealed Resident #45 was cognitively intact with a BIMS score of 13 out of 15. Resident #45 had no impairments to his extremities and used a walker. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #45 had a vertical transfer pole next to his bed. 3. Record review Resident #45 did not have a physician's order for a vertical transfer pole. Resident #45 did not have documentation in his care plan for a vertical transfer pole. Resident #45 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #45 was a moderate fall risk. K. Resident #17 1. Resident status Resident #17, age lower than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included mild cognitive impairment, osteoarthritis, and dementia. The [DATE] MDS assessment revealed Resident #17 was cognitively intact with a BIMS score of 14 out of 15. Resident #17 had no impairments to his extremities and used a walker. The resident had no physical restraints documented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #17 had a vertical transfer pole next to their bed. 3. Record review Resident #17 did not have a physician's order for a vertical transfer pole. Resident #17 did not have documentation in his care plan for a vertical transfer pole. Resident #17 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #17 was a moderate fall risk. L. Resident #21 1. Resident status Resident #21, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included osteoarthritis of the hip, diastolic (congestive) heart failure, bilateral osteoarthritis of knees, age-related macular degeneration, and fatigue. The [DATE] MDS assessment revealed Resident #21 was mildly cognitively impaired with a BIMS score of nine out of 15. Resident #21 had no impairments to his extremities and used a walker. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #21 had a vertical transfer pole next to his bed. 3. Record review Resident #21 did not have a physician's order for a vertical transfer pole. Resident #21 did not have documentation in his care plan for a vertical transfer pole. Resident #21 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #21 was a moderate fall risk. M. Resident #42 1. Resident status (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #42, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included age-related osteoporosis, dementia, history of falls, systolic (congestive) heart failure, and abnormalities of gait and mobility. The [DATE] MDS assessment revealed Resident #42 moderate cognitive impairment with a BIMS score of seven out of 15. Resident #42 had no impairments to her extremities and used a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #42 had a vertical transfer pole next to her bed. 3. Record review Resident #42 did not have a physician's order for a vertical transfer pole. Resident #42 did not have documentation in her care plan for a vertical transfer pole. Resident #42 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #42 was a high fall risk. N. Resident #47 1. Resident status Resident #47, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic diastolic heart failure and glaucoma (eye disease). The [DATE] MDS assessment revealed Resident #47 cognitively intact with a BIMS score of 14 out of 15. Resident #47 had no impairments to her extremities and used a walker. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #47 had a vertical transfer pole next to her bed. 3. Record review Resident #47 did not have a physician's order for a vertical transfer pole. Resident #47 did not have documentation in her care plan for a vertical transfer pole. Resident #47 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #47 was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. Resident #54 1. Resident status Resident #54, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic pain syndrome, muscle wasting and atrophy, generalized muscle weakness, and abnormalities of gait and mobility. The [DATE] MDS assessment revealed Resident #54 cognitively intact with a BIMS score of 15 out of 15. Resident #54 had impairment to one side of her lower extremities and used a walker and a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #54 had a vertical transfer pole next to her bed. 3. Record review Resident #54 did not have a physician's order for a vertical transfer pole. Resident #54 did not have documentation in her care plan for a vertical transfer pole. Resident #54 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #54 was a moderate fall risk. P. Resident #4 1. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included chronic pain syndrome, stage three chronic kidney disease, abnormal involuntary movements, mild cognitive impairment, tremors, repeated falls, and muscle wasting and atrophy. The [DATE] MDS assessment revealed Resident #4 moderate cognitive impairment with a BIMS score of 12 out of 15. Resident #4 had no impairments to her extremities and used a walker and a wheelchair. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #4 had a vertical transfer pole next to her bed. 3. Record review Resident #4 did not have a physician's order for a vertical transfer pole. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #4 did not have documentation in her care plan for a vertical transfer pole. Resident #4 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #4 was a high fall risk. Q. Resident #7 1. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included dementia, stage three chronic kidney disease, and chronic pain syndrome. The [DATE] MDS assessment revealed Resident #7 moderate cognitive impairment with a BIMS score of eight out of 15. Resident #7 had no impairments to her extremities and did not use assistance devices for ambulation. The resident had no physical restraints documented. 2. Observations On [DATE] at approximately 2:00 p.m., observations revealed Resident #7 had a vertical transfer pole next to her bed. 3. Record review On [DATE] (during the survey) Resident #7 had a physician's order for a vertical transfer pole in the bathroom. Resident #7's ADL care plan had an intervention to use a transfer pole in the bathroom to assist with standing up from the toilet on [DATE] (during the survey). Resident #7 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #7 was a high fall risk. R. Resident #58 1. Resident status Resident #58, age greater than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included stage two chronic kidney disease, bilateral osteoarthritis of knees, low back pain, and generalized muscle weakness. The [DATE] MDS assessment revealed Resident #58 was cognitively intact with a BIMS score of 15 out of 15. Resident #58 had no impairments to his extremities and did not use assistive devices for ambulation. The resident had no physical restraints documented. 2. Observations (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at approximately 2:00 p.m., observations revealed Resident #58 had a vertical transfer pole next to their bed. 3. Record review On [DATE] (during the survey) Resident #58 had a physician's order for a vertical transfer pole in the bathroom. Resident #58's ADL care plan had an intervention to use a transfer pole in the bathroom to assist with standing up from the toilet on [DATE] (during the survey). Resident #58 did not have a safety risk assessment for a vertical transfer pole. A fall risk assessment completed on [DATE] revealed Resident #58 was a moderate fall risk. S. Resident interviews Resident #45 and Resident #33 were interviewed together on [DATE] at 6:00 p.m Resident #45 said he and his wife had transfer poles next to their beds. He said his pole was removed by staff and the staff told him he could not have a transfer pole. Resident #33 said her husband used her transfer pole more than she did. Resident #45 said when he got out of bed he had to reach across the gap between his and his wife's bed to use her transfer pole to make it easier for him to get up. He said it was a large gap since each bed was placed against different walls. He said he feared falling but needed to use Resident #33's transfer pole to continue being independent. T. Staff interviews 1. The staff development coordinator (SDC) was interviewed on [DATE] at 6:07 p.m. The SDC said the therapy department placed vertical transfer poles and sometimes they were placed by the maintenance team. The SDC said there needed to be an indication for a resident to need the transfer pole. She said once there was a need identified, the resident needed to be assessed for safety and a physician's order was needed. She said the restorative registered nurse (RRN) completed almost everything the resident needed to get a transfer pole. The SDC was unsure how staff checked for the proper placement of the transfer pole and where the transfer pole needed to be placed. She said the assessment was supposed to make sure the resident would not get entrapped or cause injury. She said she was unsure how she would know if a transfer pole was safe for a resident. The SDC said the incident with Resident #61 was not investigated and her statement was never taken by leadership. The SDC said she was informed the resident was found stuck and unconscious. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 6:07 p.m. LPN #2 said a resident was assessed by the nurse and therapy before a transfer pole was installed. She said the RRN placed the transfer poles and sometimes maintenance placed the transfer poles. She said the transfer poles were documented in each resident's care plan and the resident needed to be reassessed periodically for safety. LPN #2 said she had not received education about the transfer poles and she was unsure where the poles were supposed to be placed or how to know if the transfer poles were right for the resident. 3. CNA #7 was interviewed on [DATE] at 6:07 p.m. CNA #7 said she was the staff member who discovered Resident #61 on [DATE]. She said the resident attempted to self-transfer and got stuck between his bed and the transfer pole. CNA #7 said Resident #61's knees were stuck and he was facing the head of the bed but he was bent backward toward the foot of the bed. She said she triggered the resident's emergency call light and tried to get his knees unstuck. CNA #7 said the resident was breathing but very slow and weird when she found him. CNA #7 said Resident #61 was with me but he was not with me. She said she was unable to recall when the resident was last seen before the incident. She said she was not interviewed about what happened. 4. CNA #8 was interviewed on [DATE] at 6:07 p.m. CNA #8 said if[TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50314 Based on record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored in accordance with professional standards in two of three medication storage refrigerators. Specifically, the facility failed to maintain a medication refrigerator temperature log for the facility vaccine refrigerator and the medication refrigerator. Findings include: I. Professional reference According to the Centers for Disease Control (CDC), Handle with Care: Protect your Vaccine, Protect Your Patients, (revised on 3/19/24) was retrived on 11/26/24 from https://www.cdc.gov/vaccines/hcp/admin/storage/downloads/vaccine-storage-temperatures.pdf Keep your storage units and vaccines within the appropriate temperature ranges. Check and record storage unit min/ma (minimum/maximum) temperatures at the start of each workday. II. Facility policy and procedure The Medication Storage policy, revised on 1/25/24, was provided by the nursing home administrator (NHA) on 11/21/24 at 2:43 p.m. It documented in pertinent part, All drugs and biologicals will be stored in locked compartments (medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. II. Record review The vaccine and medication refrigerator temperature log records from 10/1/24 to 11/19/24 were provided by registered nurse (RN) #1 on 11/20/24 at 2:16 p.m. Out of 50 days of documentation opportunities, vaccine refrigerator temperatures were documented on 16 of those days. Out of 50 days of documentation opportunities, medication refrigerator temperatures were documented on 24 of those days. III. Staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 was interviewed on 11/20/24 at 2:16 p.m. RN #1 said the medication and vaccine refrigerator temperatures should be logged every night by night shift nurses. RN #1 said many days had not been documented in the medication and vaccine refrigerator temperature logs. RN #1 said it was important to ensure medications were safely stored at the correct temperature so they could be safely administered to residents. The director of nursing (DON) was interviewed on 11/22/24 at 10:27 a.m. The DON said that all floor nurses were responsible for recording medication refrigerator temperatures. The DON reviewed the medication and vaccine refrigerator temperature logs between 10/1/24 and 11/19/24. The DON said many days had not been documented in the temperature logs. The DON said the vaccine and medication refrigerator temperatures should be documented daily. The DON said that if these refrigerators were not monitored by staff, then medications could expire or not work correctly for residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure two (#43 and #14) of seven residents received food and fluids prepared in a form designed to meet their needs per speech therapy recommendation, physician's orders and the resident's care plan out of 41 sample residents. Specifically, the facility failed to ensure Resident #43 and Resident #13, who were prescribed a mechanically altered diet texture, were served food in the correct form. Findings include: I. Facility policy and procedure The Therapeutics Diets policy, revised on 6/7/24, was provided by the corporate consultant (CC) on 11/21/24 at 1:33 p.m. It read in pertinent part, Each resident has a specific food and beverage preparation detailed on a tray card so accurate diets are served. Therapeutic diets are prepared and served according to written orders from the provider and are planned and served with supervision from the dietary manager (DM) or registered dietician (RD). Specific diets and textures are referenced in the diet manual with specific content and preparation. A current diet manual is available for reference to attending physicians, nursing service and dietary staff. Residents and/or their power of attorney (POA) may refuse the recommended diet. In this case the facility must provide education, provide and ask for a signature on a dietary waiver and increase monitoring at meal times. II. Facility's diet manual The Diet Manual, revised August 2015, was provided by the nursing home administrator (NHA). It read in pertinent, Dysphagia mechanically altered: This level consists of foods that are moist, soft textured and easily formed into a bolus. Meats are ground or minced no larger than one-quarter-inch pieces: they are still moist with some cohesion. This diet is a transition from the pureed textures to more solid textures. Chewing ability is required. The textures on this level are appropriate for individuals with mild to moderate oral and/or pharyngeal dysphagia. Breads: Soft pancakes well moistened with syrup or sauce. Pureed bread mixes, pregelled or slurried breads that are gelled through entire thickness. Avoid all other breads. Vegetables:All soft, well-cooked vegetables should be smaller than half-an-inch and easily mashed with a fork. Avoid cooked corn and peas, broccoli, cabbage, brussels sprouts, asparagus or other fibrous non-tender or rubbery cooked vegetables. III. Facility recipes (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Salisbury steak Mechanical soft: Grind portions needed from regular prepared recipe into one eighth inch pieces. B. Garlic cheese biscuit It is recommended to serve pureed bread/biscuit or gelled bread for dysphagia diets, but if the speech language pathologist (SLP) at your facility signs and approves regular breads on an individual basis, chop regular portions. Make sure all particles are no more than half-an-inch by half-an-inch. -The facility served cooked biscuits with a slice of American cheese melted over the top (see observations below). IV. Resident #43 A. Resident status Resident #43, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician order (CPO) diagnoses included dementia, acute cough and dysphagia (difficulty swallowing). The 11/4/24 minimum data set (MDS) assessment revealed Resident #43 t had long-term and short-term memory problems and was severely cognitively impaired per staff assessment. The MDS assessment indicated Resident #43 required a mechanically altered diet. B. Record review A review of the November 2024 CPO revealed the resident had a physician's order that indicated the resident was prescribed a mechanical soft diet and was to be served his food on a lipped plate, ordered on 10/14/24. A review of Resident #43's electronic medical record (EMR) did not reveal a dietary waiver indicating the resident was able to consume regular textured food cut-up (see interview below). C. Observation The following was observed on 11/21/24 at 11:44 a.m.: Resident #43 was served a Salisbury steak and a dinner roll both were cut into bite-sized pieces. -The facility failed to serve theSalisbury steak ground and puree or gel the dinner roll as indicated on the recipe (see recipe above). V. Resident #14 A. Resident status (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO diagnoses included dementia, Parkinsonism (degenerative disease that causes involuntary movements) and dysphagia. The 10/12/24 MDS assessment revealed Resident #14 t had long-term and short-term memory problems and was severely cognitively impaired per staff assessment. The MDS assessment indicated Resident #14 required a mechanically altered diet. B. Record review A review of the November 2024 CPO revealed the resident had a physician's order that indicated the resident was prescribed a mechanical soft diet and nectar thick liquids, ordered on 8/20/2020. A review of Resident #14's EMR did not indicate a dietary waiver that indicated the resident was able to consume regular textured food cut-up. The resident had a dietary waiver in place to consume thin liquids versus nectar thick (see interview below). C. Observations The following was observed on 11/21/24 at 11:44 a.m.: Resident #43 was served a regular textured Salisbury steak and a dinner roll both were cut into bite-sized pieces. -The facility failed to serve the Salisbury steak ground and puree or gel the dinner roll as indicated on the recipe (see recipe above). VI. Staff interviews Dietary aide (DA) #3 was interviewed on 11/21/24 at 11:50 a.m. DA #3 said Resident #43 and Resident #14 had waivers in place to eat regular or bite-sized textured foods. DA #3 said if a resident's plate looked like the wrong texture she would send it back to the kitchen to be fixed. DA #3 said she was unaware bread needed to be pureed or slurried on a mechanical soft diet. -However, review of the resident's EMR did not indicate dietary waivers were in place for the residents to receive regular textured food (see record review above). The cook (CK) was interviewed on 11/21/24 at 11:50 a.m. The CK said Resident #43 and Resident #14 were allowed to have bread and the Salisbury steak was the correct texture. The CK said she was unaware the bread needed to be pureed or gelled for residents who were prescribed a mechanical soft diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the CC and the registered dietitian (RD) were interviewed together on 11/21/24 at 12:57 p.m. The RD said the facility had not implemented the International Dysphagia Diet Standardisation Initiative (IDDSI) program yet. She said the facility modified resident's diets based on what the SLP recommended. The NHA, the CC and the RD said they were unaware the facility's diet manual indicated the mechanically soft texture required the bread to be pureed or slurried. The RD said although the Salisbury steak was made from ground beef it should not have been formed into a steak shape and cut into bite-sized pieces. The RD said the residents should have been served ground beef with the gravy.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40467 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to implement an effective system to identify and address multiple concerns related to quality of care, including accidents/hazards, in which the facility failed to conduct safety risk assessments for residents with transfer poles which rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely. Findings include: I. Facility policy The Quality Assurance Performance Improvement (QAPI) policy, updated 9/30/24, was provided by the nursing home administrator (NHA) on 11/18/24 at 1:21 p.m. The policy documented in pertinent part, It is the policy that the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life. Develop and implement appropriate plans of action to correct identified quality deficiencies. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. The QAPI plan should address the following elements: -Design and scope of the facility's QAPI program and QAA (Quality Assessment and Assurance) committee responsibilities and actions; -Policies and procedures for feedback, data collection systems, and monitoring; and, -Process addressing how the committee should conduct activities necessary to identify and correct quality deficiencies. Key components of this process include: -Tracking and measuring performance; -Establishing goals and thresholds for performance improvements; -Identifying and prioritizing quality deficiencies; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Systematically analyzing underlying causes of systemic quality deficiencies; -Developing and implementing corrective action or performance improvement activities; and, -Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. The facility takes actions aimed at performance improvement as documented in QAA committee meeting minutes and action plans. Performance/success of the actions should be monitored and documented in subsequent QAA committee or sub-committee meetings. To ensure improvements are sustained, the effectiveness of performance improvement activities should be monitored in QAA committee meetings in accordance with the QAPI plan, but no less than annually. II. Cross-referenced citations affecting quality of care identified during the facility's recertification on 11/22/24 Cross-reference F689: The facility failed to ensure the resident environment remained as free of accident hazards as possible. The facility failed to complete a safety risk assessment before placing resident transfer poles and failed to investigate after a transfer pole accident. Additional accident/hazards failures were identified related to fall prevention and smoking while wearing a nasal cannula and a turned off oxygen tank. The deficiency was cited at a K scope and severity, immediate jeopardy, pattern. Cross-reference F686: The facility failed to prevent a resident from developing a pressure ulcer and failed to ensure interventions were consistently in place to prevent the pressure ulcer from worsening. The deficiency was cited at a G scope and severity, actual harm, isolated. Cross-reference F880: The facility failed to maintain an effective water management plan. The deficiency was cited at a F scope and severity, potential for more than minimal harm, widespread. Cross-reference F600: The facility failed to protect residents from physical abuse. The deficiency was cited at a D scope and severity, potential for more than minimal harm, isolated. Cross-reference F761: The facility failed to maintain appropriate temperatures in the medication refrigerator and the vaccine refrigerator. The deficiency was cited at an E scope and severity, potential for more than minimal harm, pattern. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F677: The facility failed to provide bathing per resident preferences. The deficiency was cited at a D scope and severity, potential for more than minimal harm, isolated. Cross-reference F908: The facility failed to use medically rated blood pressure cuffs to obtain residents blood pressures. The deficiency was cited at a D scope and severity, potential for more than minimal harm, pattern. Cross-reference F805: The facility failed to ensure residents were served food in a form designed to meet residents' needs per physician's orders. The deficiency was cited at a D scope and severity, potential for more than minimal harm, isolated. III. Staff interviews The NHA and the director of nursing (DON) were interviewed together on 11/22/24 at 2:12 p.m. The NHA said the QAPI committee met monthly to continuously improve processes and meet standards. The NHA said all managers, the medical director, the pharmacist and the licensed social worker from a sister facility participated in the monthly QAPI meetings. The NHA said during the meetings, each manager reviewed their department reports and as a team, the committee tried to identify concerns, problem solve as a group and discuss how the facility would address the concern in attempts to resolve it. The NHA said the QAPI committee received additional insight from line staff, resident council, care conferences and morning nurse reports. The DON said each department would determine the root cause of their department concern. She said the department managers would bring their department concerns to the QAPI committee if they felt they needed to expand the discussion and analysis. The NHA said the QAPI committee created and implemented performance improvement projects/plans. She said the QAPI committee reviewed the implemented plans, made the determination if the identified concern was resolved and if the facility was able to effectively sustain system change. The NHA said if the plan did not produce a sustaining resolution to the concern, the committee would attempt to adjust the plan in efforts to resolve the concern. The DON said the QAPI committee reviewed falls monthly in the QAPI committee meeting. She said the committee looked at the number of falls in each month, whether the falls were witnessed or not, residents with multiple falls and where the falls occurred. The DON said if the facility had a resident fall several times in one month, the committee discussed the nature of the falls in an effort to gain additional insight and perspective that may not have already been identified. The DON said part of the root cause analysis was to identify if staff were properly educated and understanding why the falls happened. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON said the process failed because the committee did not recognize what needed to be documented and not enough questions were asked to determine the full factor/cause of the falls. The NHA said the QAPI committee did not review smoking with a nasal cannula on or smoking near a turned off oxygen tank as a QAPI concern because the staff had not seen or reported to management that it was a concern. She said the resident involved in the situation was usually good about taking his oxygen off before he went outside to smoke. The DON said the QAPI committee did not review the residents' transfer poles and lack of safety assessments. The DON said the QAPI committee did not identify the assessments were not completed prior to the installation of the transfer poles. The NHA said pressure ulcers were reviewed in the QAPI committee meetings. The DON said pressure ulcers were reviewed during QAPI committee meetings. She said the team reviewed the residents who currently had pressure ulcers, identified if the pressure ulcers were improving, what treatments were being provided and received insight from the medical director on the pressure ulcers. The DON said the facility needed to work on improving documenting refusals of interventions, increasing observations of the resident and addressing concerns with the resident. The NHA said food textures were not reviewed in QAPI meetings. She said menus were reviewed but the committee had not discussed if the residents received the appropriate textured diets. The DON said diet order education with the kitchen staff had been discussed in the care concern at-risk meetings. The NHA said the registered dietitian (RD) had a weekly report of everyone with weight concerns and choking hazards. The NHA said the RD discussed any related concerns with the IDT, speech therapy and the kitchen staff and offered her recommendations. The DON said there had been a lot of confusion related to mechanical soft textures and she would like to look at new text diet texture processes and education. The DON said the use of medical grade blood pressure cuffs was not reviewed in QAPI meetings. The DON said she was not aware there was a problem with the blood pressure cuffs the facility was using. The NHA said residents' bathing preferences and choices had not been identified as a concern in QAPI meetings. She said residents did not usually address bathing preferences as a concern. She said the bathing preferences concern may have been addressed under the grievance process but the QAPI committee had not identified this as a concern. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said resident-to-resident altercations were reviewed in QAPI committee meetings. She said the social services director (SSD) reviewed every occurrence identified in the previous month. The NHA said the QAPI committee discussed the occurrences to help identify trends that needed to be addressed. The NHA said the committee tried to find the root cause of the concern, looked at what caused each incident and tried to determine what could be put in place to prevent the incident from happening again. She said for resident-to-resident altercations, the team looked at interventions to help separate residents when needed and de-escalate the situations. The NHA said staff to resident physical abuse was discussed in QAPI meetings but the committee had not identified the concerns as a facility trend. The NHA and the DON said the facility had not looked at the lack of education provided to the temporary traveling staff. The DON said she recently requested the education the contract agency provided to the traveling staff. The NHA said refrigerator temperatures were reviewed in QAPI meetings, but not recently. She said in the past, audits identified concerns with consistent tracking of the temperature in the kitchen but refrigerators storing medications and vaccines had not been reviewed in QAPI committee meetings or identified as a concern. The NHA said the water management plan in relation to Legionella had not been reviewed in the QAPI meetings or identified as a concern. The NHA said the facility would look at all the identified concerns addressed and would relook at the facility's QAPI committee process, add additional audits and review how the QAPI committee analyzed facility concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50314 Based on record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to implement an effective water management plan. Findings include: I. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, last reviewed 3/15/24, was retrieved on 11/26/24 from https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html It read in pertinent part, Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible. Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 F, 25-45 C). Legionella may grow at temperatures as low as 68 F (20 C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. II. Facility policy and procedure The Legionella water management program policy was provided by the nursing home administrator (NHA) on 11/20/24 at 11:14 a.m. It documented in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is the policy of the Veterans Community Living Centers (VCLCs) to establish water management plans for reducing risk of legionella and other opportunistic pathogens in the facility's water systems. It is also the policy of the VCLCs to establish primary and secondary strategies for the prevention and control of legionella infections. C. Record Review The water management plan documentation was provided by the director of maintenance (DOM) on 11/20/24 at 12:43 p.m. The plan documented the facility had completed a legionella test on 7/18/24 which was negative. -The facility failed to document the flushing of dead legs and low-flow piping runs on all three hallways where residents resided. An email was received from the director of nursing (DON) on 10/22/24 at 9:54 a.m. The DON documented that seven rooms available for resident use had been vacant for seven contiguous days or more between 9/23/24 and 11/22/24. D. Staff interviews The DON and the NHA were interviewed together on 11/20/24 at 12:43 p.m. The DOM said all empty rooms in the facility had hot water run though all dead legs and low-flow piping runs of empty resident rooms in the facility every two weeks. The NHA said the facility flushed water in empty rooms every other week. The DOM and the NHA both said flushing the water every two weeks was sufficient to prevent the growth of legionella. The DOM said the facility tested for legionella annually. The infection preventionist (IP) and the DON were interviewed together on 11/22/24 at 9:03 a.m. The IP said she was not directly involved in the water management plan because that was the responsibility of the maintenance department in the facility. The IP said she thought water had to be flushed weekly to prevent the spread of waterborne pathogens such as legionella. The DON said she also thought water had to be flushed weekly in dead legs to prevent legionella growth. The IP and the DON both said they were not aware the facility practice was to flush water in dead legs and low-flow piping runs every two weeks.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to maintain all mechanical, electrical and patient care equipment in safe operating condition. Specifically, the facility failed to ensure facility staff used blood pressure cuffs rated for medical use. Findings include: I. Professional reference According to the [NAME] Advantage for Basic Nursing handbook, third edition, retrieved on 11/25/24 from Treas, [NAME] S., et al. [NAME] Advantage for Basic Nursing: Thinking, Doing, and Caring. F. A. [NAME] Company, 2022., Blood Pressure - Practical Knowledge, Electronic blood pressure monitors may be less accurate than those with an aneroid monitor (a manual blood pressure measuring device). To ensure accuracy, you should auscultate (listen to) a baseline blood pressure before initiating automatic monitoring. Ensure devices are rated for medical use. The width of the blood pressure cuff bladder of a properly fitting cuff will cover approximately two-thirds of the length of the upper arm for an adult, and the entire upper arm for a child. Alternative sites you can use are the forearm, thigh, or calf. However, systolic pressure may be 20 to 30 mmHg (millimeters of mercury) higher in the lower extremities than in the arms, but diastolic pressures are similar. Abnormally high or low blood pressure readings should be rechecked by the provider. II. Facility policy The Medical Equipment policy, revised 7/1/24, was provided by the corporate consultant (CC) on 11/22/24 at 1:39 p.m. It documented that all durable medical equipment (DME) to be used for resident assessment and monitoring would be deemed medically rated for use in health care facilities. III. Observations On 11/20/24 at 8:52 a.m., licensed practical nurse (LPN) #1 was observed using a Veridian Healthcare model 01-574 model wrist type blood pressure cuff to take Resident #213's blood pressure. -LPN #5 did not use a blood pressure cuff rated for medical use to obtain Resident #213's blood pressure (see professional references above and interview below). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:23 a.m., registered nurse (RN) #4 was observed taking Resident #33's blood pressure using a W1101L wrist type blood pressure cuff. -RN #4 did not use a blood pressure cuff rated for medical use to obtain Resident #33's blood pressure (see professional references above and interview below). IV. Record Review On 11/20/24 at 11:57 a.m., the director of nursing (DON) said (via email) that she could not find manufacturer's instructions for the W1101L wrist type blood pressure cuff or the Veridian Healthcare model 01-574 model wrist type blood pressure cuff that documented either device was rated for medical use. The DON said both blood pressure cuffs had been removed from use in the facility on 11/20/24. V. Staff interviews LPN #1 was interviewed on 11/20/24 at 8:55 a.m. LPN #1 said she enjoyed using the Veridian Healthcare model 01-574 model wrist type blood pressure cuff to obtain blood pressures on residents. LPN #1 said she did not know if the blood pressure cuff was rated for medical use. LPN #3 was interviewed on 11/21/24 at 1:17 p.m. LPN #3 said she had used both the Veridian Healthcare model 01-574 model wrist type blood pressure cuff and the W1101L wrist type blood pressure cuff to obtain resident blood pressure readings. LPN #3 said the blood pressure cuffs were stored in a protective case on each medication cart to use whenever nurses needed to. LPN #3 said she did not know if the devices were rated for medical use. The DON was interviewed on 11/22/24 at 10:27 a.m. The DON said she had obtained the blood pressure cuffs from a medical supply company but did not verify if the blood pressure cuffs were rated for medical use. The DON said she was surprised to learn the Veridian Healthcare model 01-574 model wrist type blood pressure cuff and the W1101L wrist type blood pressure cuff were not rated for medical use. The DON said it was important for the facility to use blood pressure cuffs rated for medical use to ensure residents' vital signs were accurate. The DON said residents could receive blood pressure medications when they were not needed if the facility relied on the accuracy of a non-medically rated device to obtain resident blood pressures.