STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065400	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Post Acute and Rehabilitation	7395 W Eastman Pl Lakewood, CO 80227

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on record review and interviews, the facility failed to ensure consent was obtained for the use of psychotropic medications for one (#4) of five residents reviewed for unnecessary medications out of 17 sample residents. Specifically, the facility failed to ensure informed consents, which included the risks associated with taking a psychotropic medication, were obtained for Resident #4 prior to the administration of a psychotropic medication. Findings include: I. Facility policy and procedure The Use of Psychotropic Medications policy and procedure, undated, was received from the regional director of clinical services (RDCS) on 3/27/25 at 1:22 p.m. It revealed in pertinent part, It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (written consent form, narrative note). II. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included type two diabetes mellitus (abnormal glucose control), major depressive disorder and heart failure. The 2/23/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment revealed Resident #4 received antipsychotic medications, had depression and was taking antidepressants. B. Record review The March 2025 CPO revealed the following physician's orders: -Bupropion 150 milligrams (mg), one tablet by mouth once daily for depression, ordered on 2/16/25; and, -Bupropion 300 mg, one tabled by mouth once daily for depression, ordered on 3/22/25. The 2/16/25 comprehensive care plan revealed Resident #4 was on antidepression medication due to a diagnosis of depression. Interventions included administering medications as ordered by the physician and observing the resident's mood and response to the medications. -Review of Resident #4's electronic medical records (EMR) failed to reveal an informed consent, which included the risks associated with taking the medication were discussed with the resident or resident representative prior to the administration of the medication. Review of the resident's EMR on 3/26/25 revealed the facility obtained informed consent from Resident #4 on the use of Bupropion on 3/26/25. -The facility failed to obtain informed consent from Resident #4 prior to the first administration of Bupropion on 2/16/25. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/26/25 at 2:10 p.m. She said it was the responsibility of the admitting nurse to obtain all consents for treatment including informed consents on psychotropic medications. LPN #1 said the resident had the right to refuse or accept taking medication and consent should be obtained from the resident or responsible party prior to the first administration. LPN #1 reviewed Resident #4's EMR and was unable to locate an informed consent for the use of Bupropion and said she would follow up on this matter. (see record review above). The social service director (SSD) was interviewed on 3/27/25 at 12:26 p.m. She said informed consent should be obtained from the resident or responsible party to ensure they knew the risks and benefits of taking the medication. The director of nursing (DON) was interviewed on 3/27/25 at 1:39 p.m. She said the floor nurses were responsible to ensure informed consent was obtained on medications during the admission process. She said the consent forms were part of the packet set-up to be completed for admissions. The DON said informed consent was important so the resident was aware of the risks and benefits of the medications they were taking . The DON said every new admit chart was audited by herself or the assistant director of nursing (ADON). The DON said she was unable to determine how the consent for this medication was missed.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on record review and interviews, the facility failed to develop and implement a comprehensive care plan for two (#18 and #15) of three residents reviewed for care plans out of 17 sample residents. Specifically, the facility failed to: -Ensure Resident #18's comprehensive care plan addressed his use of oxygen; and, -Ensure Resident #15 had a care plan for the use of splint and contractors. Findings include: I. Facility policy and procedure The Comprehensive Care Plan policy, undated, was provided by the regional director of clinical services (RDCS) on 3/27/25 at 1:22 p.m. It read in pertinent part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. The comprehensive care plan will be developed within 7 (seven) days after the completion of the comprehensive MDS (minimum data set) assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. II. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included oxygen dependency, morbid (severe) obesity due to excess calories, shortness of breath and dependence on supplemental oxygen. The 1/31/25 MDS assessment revealed the resident was cognitively intact with a mental status (BIMS) score of 15 out of 15. He was independent with eating. The MDS assessment indicated he received oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations Resident #18 was observed three times between 3/24/25 and 3/27/25 in his room. He had a nasal cannula in place during all observation. His oxygen tubing was attached to his portable oxygen or his oxygen concentrator during observations. C. Record review Review of Resident #18`s comprehensive care plan on 3/24/25 did not reveal a care plan for oxygen therapy. Review of Resident #18's electronic medical record (EMR) revealed the resident did not have a physician's order for oxygen use. Cross-reference F695: failure to ensure a physician's order was obtained for oxygen therapy. D. Staff interviews Registered nurse (RN) #1 was interviewed on 3/26/25 at 9:37 a.m. RN #1 said if a resident was receiving oxygen therapy, there should be a physician's order and a care plan. She said she reviewed Resident #18's EMR and was not able to find the care plan for Resident #18's oxygen therapy and flow rate. The assistant director of nursing (ADON) was interviewed on 3/26/25 at 9:47 a.m. The ADON said a care plan and a physician order should be in place for oxygen therapy. She said she was not able to find a care plan for the resident's use of oxygen. The director of nursing (DON) was interviewed on 3/26/25 at 2:19 p.m. She said the use of oxygen required a physician's order as well as a care plan. She said these documents were crucial for the staff to know what the resident's plan of care was. She said the facility completed an audit to ensure all residents utilizing oxygen had a care plan in place. 46849 III. Resident #15 A. Resident status Resident #15, age 66, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included altered mental status, rheumatoid arthritis, osteoporosis, muscle weakness, chronic pain syndrome and cellulitis (infection of the skin of the right lower limb. The 1/23/25 MDS assessment documented the resident had moderate cognitive impairments with a BIMS score of nine out of 15. She had a functional range of motion deficit to her lower extremities. She required a wheelchair for mobility and required maximum assistance from staff for toileting, showering, dressing, bed mobility, transfers and ambulation. B. Resident interview and observation (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 was interviewed on 3/24/25 at 10:30 a.m. The resident was unable to recall how she sustained her contractures but pointed out splints on her table. She said she could not remember how long she had been using the splints but she did not like them because the splints caused her pain. The resident said she knew she had been working with therapy for a long time and her goal was to be able to straighten her legs. During the interview Resident #15 was laying on her right side with her legs bent with her heels touching her back. C. Record review The comprehensive care plan, initiated 7/16/24, revealed the resident had an alteration in musculoskeletal status related to rheumatoid arthritis and osteoporosis. Interventions (revised 7/16/24) included anticipating and meeting the residents needs, providing heat and cold applications as needed, placing the call light within reach, monitoring for fatigue, monitoring for risk of falls and monitoring signs and symptoms or complications related to arthritis. The therapy care plan, revised on 7/16/24, revealed the resident was on physical therapy (PT) services related to a spinal surgery and metabolic encephalopathy which caused weakness and deconditioning. Interventions (revised 7/16/24) included PT five times a week for four weeks for improved independence and safety with functional mobility. -The care plan did not include the presence of contractures or a medical device to treat contractures such as a splint. The March 2025 CPO revealed the following physician's orders: A review of hospital records, dated 4/29/24, revealed the resident had bilateral knee and hip contractures. The OT evaluation, dated 5/29/24, documented the resident had bilateral contractures and spasticity (involuntary muscle stiffness). The PT evaluation, dated 5/29/24, documented the resident began using a bilateral knee extension bracing for contracture management two hours daily. The PT evaluation, dated 3/20/25, documented the resident was using knee splints for up to six hours a day to improve range of motion. -However, review of Resident #15's comprehensive care plan did not reveal the use of the splints (see care plan above). D. Staff interviews (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 3/26/25 at 9:09 a.m. She said she had worked with Resident #15 for over a year and the resident had contractures in her legs the entire time. LPN #1 said therapy worked with the resident and she had knee splints for the contractures. She said the nurse management wrote all the care plans and the interventions for residents for nursing treatment and services. LPN #1 said the nursing staff utilized the care plan for resident centered interventions. The director of rehabilitation (DOR) was interviewed on 3/26/25 at 12:55 p.m. She said Resident #15 was receiving services from PT and OT. The DOR said PT had just started using a splint with the resident for her contractures. She said the nursing department would be responsible for including any devices used for contractures in the resident's care plan. The DON was interviewed on 3/27/25 at 1:47 p.m. She said the therapy department took the lead on assessing and identifying devices that were needed for the residents. The DON said the nursing department added the resident diagnosis and any treatment being received from therapy into the resident's care plan. The DON said she thought Resident #15 had only used a splint one time. She said she did not know why the splint was not included in her care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on observations, record review and interviews, the facility failed to ensure one (#15) of two residents received care and services according to acceptable standards of clinical practice out of 17 sample residents. Specifically, the facility failed to ensure residents had a physician review and order for the use of specialized medical devices for Resident #15. Findings include: I. Resident #15 A. Resident status Resident #15, age 66, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included altered mental status, rheumatoid arthritis, osteoporosis, muscle weakness, chronic pain syndrome, and cellulitis (infection of the skin) of the right lower limb. The 1/23/25 minimum data set (MDS) assessment documented the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of nine out of 15. She had a functional range of motion deficit to her lower extremities. She required a wheelchair for mobility and required maximum assistance from staff for toileting, showering, dressing, bed mobility, transfers, and ambulation. The MDS assessment failed to indicate any assistive or therapeutic devices. B. Resident interview and observations Resident #15 was interviewed on 3/24/25 at 10:30 a.m. The resident was unable to recall how she sustained her contractures but pointed out splints on her table. She said she could not remember how long she had been using the splints. The resident said she knew she had been working with therapy for a long time and her goal was to be able to straighten her legs. During the interview Resident #15 was laying on her right side with her legs bent with her heels touching her back. Resident #15 was observed on 3/25/25 at 1:15 p.m. laying in her bed on her right side with her legs bent with her heels touching her back. C. Record review The comprehensive care plan, initiated 7/16/24, revealed the resident had an alteration in musculoskeletal status related to rheumatoid arthritis and osteoporosis. Interventions included anticipating and meeting the residents' needs, providing heat and cold applications as needed, placing the call light within reach, monitoring for fatigue, monitoring for risk of falls and monitoring for signs and symptoms or complications related to arthritis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The therapy care plan, revised on 7/16/24, revealed the resident was on physical therapy (PT) services related to spinal surgery and metabolic encephalopathy which caused weakness and deconditioning. Interventions included providing PT five times a week for four weeks for improved independence and safety with functional mobility. The March 2025 CPO revealed the following physician's orders: Provide occupational therapy (OT) two times a week for four weeks, treatment may include bilateral lower extremity passive range of motion exercises, ordered on 3/18/25. Provide PT one to two times a week. The resident would tolerate knee splinting daily to improve range of motion and reduce risk of skin breakdown, ordered on 3/20/25 and effective on 3/26/25 (during the survey). -Physician visit notes dated 3/15/24 to 3/19/25 failed to reveal orders for splints or braces for contractures. A PT evaluation, dated 5/29/24, documented the resident began using a bilateral knee extension bracing for contracture management two hours daily. A PT evaluation, dated 3/20/25, documented the resident was using knee splints for up to six hours a day to improve range of motion. -Review of the March 2025 CPO revealed the resident did not have a physicians' order for splint use until 3/26/25 (during the survey), although documentation revealed PT had been using the knee splints since 5/29/24. II. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/26/25 at 9:09 a.m. She said she had worked with Resident #15 for over a year and the resident had contractures in her legs the entire time. LPN #1 said therapy worked with the resident and she had knee braces for the contractures. LPN #1 said she did not know if there was a physician's order for the use of the splints. She said there should have been a physician's order prior to the use of the splints. The director of rehabilitation (DOR) was interviewed on 3/26/25 at 12:55 p.m. She said Resident #15 was receiving services from PT and OT. The DOR said PT had just started using a splint with the resident for her contractures. -However, record review revealed the PT was using splints since 5/29/24 (see record review above). The DOR said she did not know if the physician had to write an order for the use of splints or braces for Resident #15 because the resident was paying privately and not through her insurance. The DOR said she did not know how the staff knew how to provide person-centered care without the physician's. She said the therapist working with Resident #15 had told her that she had entered the order into the electronic medical record (EMR) on 3/20/25 but there was no record of this. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/27/25 at 1:47 p.m. She said the therapy department took the lead on assessing and identifying devices that may be needed for the residents. The DON said once a trial of the device took place, the therapy department notified the nursing department and the physician would be contacted for an order. The DON said it was important to ensure there was a physician's order prior to the use of any devices such as braces or splints for the collaboration of care with all departments. The DON said she was not aware the resident did not have a physician's order for the splint until the survey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on observations, record review and interviews, the facility failed to ensure one (#18) of three residents who required respiratory care received the care consistent with professional standards of practice out of 17 sample residents. Specifically, the facility failed to: -Obtain a physician`s order for oxygen therapy was in place for Resident #18.  -Ensure Resident #18`s portable oxygen tank was operating when in use. Findings include: I. Facility policy and procedure The Oxygen Administration policy, undated, was provided by the regional director of clinical services (RDCS) on 3/27/25 at 1:22 p.m. It read in pertinent part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. Personnel authorized to initiate oxygen therapy include physicians, RNs (registered nurse), LPNs (licensed practical nurse) and respiratory therapists. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. II. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included oxygen dependency, morbid (severe) obesity due to excess calories, shortness of breath and dependence on supplemental oxygen. The 1/31/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a mental status (BIMS) score of 15 out of 15. He was independent with eating. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment indicated he received oxygen therapy. B. Observations On 3/24/25 at 10:21 a.m. Resident #18 was sitting in his wheelchair in his room He had a nasal cannula in his nose and the tube was attached to his portable oxygen tank. He had his portable oxygen tank on the back of his wheelchair. The portable oxygen tank was not turned on. He said he was unsure about the oxygen concentration setting. On 3/25/25 at 9:33 a.m. Resident #18 was in his room. He was sitting in his wheelchair and he had a nasal cannula in place. The oxygen tubing was attached to his oxygen concentration tank. The concentrator flow rate was set to 2.5 liters per minute (LPM). On 3/26/25 at 9:04 a.m. Resident #18 was sitting in his wheelchair in his room with the nasal cannula in his nose. The oxygen tubing was attached to the oxygen concentrator. The concentrator flow rate was set to 2 LPM. C. Record review Review of Resident #18`s March 2025 CPO revealed the resident did not have a physician's order for oxygen therapy. III. Staff interviews Certified nurse aide (CNA) # 1 was interviewed on 3/26/25 at 9:30 a.m. CNA #1 said the nurse notified the CNAs of the appropriate oxygen flow for the residents. He said they also had a report sheet that the assistant director of nursing (ADON) updated with the resident oxygen levels. He said the report sheet would show the residents oxygen flow rate. He said if a resident was using a portable oxygen tank, the resident's oxygen tubing should be reattached back to the concentrator upon returning to their room. He said the CNA might have forgotten to reattach Resident #18`s oxygen tubing to his concentrator after he returned to his room. Registered nurse (RN) #1 was interviewed on 3/26/25 at 9:37 a.m. RN #1 said the oxygen flow rate was located in the medication administration record (MAR) or on the report sheet. She said there should be a physician's order for oxygen therapy and it should be included on the resident's care plan. She was not able to find the physician`s order or the care plan for Resident #18's oxygen therapy and flow rate. She said the portable oxygen tank should be on when in use. She said residents should be switched over to the concentrator when they returned to their room. Cross- reference F656: failure to ensure Resident #18 had a care plan for the use of oxygen. The ADON was interviewed on 3/26/25 at 9:47 a.m. The ADON said a physician's order should be obtained and include the use of oxygen therapy and the flow rate. She said the hospital discharge paperwork should also tell them the correct therapies and flow rate ordered for the residents. She said a care plan and a physician's order should be in place for oxygen therapy. She was not able to find either documents in the resident's medical record. She said the portable tank should be on when in use. She said she will put the order in right away. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/26/25 at 2:19 p.m. She said the use of oxygen required a physician's order as well as a care plan. She said these documents were crucial for the staff to know what the residents` plan of care was. She said portable oxygen should be turned on when in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#75) of one resident reviewed for dialysis care out of 17 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to consistently complete the pre-dialysis facility assessment section on dialysis communication form for Resident #75. Findings include: I. Facility policy and procedure The Hemodialysis policy and procedure, undated, was received from the regional director of clinical services (RDCS) on 3/27/25 at 1:22 p.m. It revealed in pertinent part, The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: -Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; -Physician/treatment orders, laboratory values, and vital signs; -Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; -Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; -Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; -Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site; -Changes and/or declines in condition unrelated to dialysis; and, -The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. II. Resident #75 A. Resident status Resident #75, age greater than 65, admitted on [DATE]. According to the March 2025 computerized physician orders (CPO) diagnoses included metabolic encephalopathy, congestive heart failure (fluids overload on the heart), end stage renal disease (abnormal kidney function) and type two diabetes mellitus (abnormal glucose control). The 3/21/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status score (BIMS) score of ten out of 15. The MDS assessment revealed he had renal insufficiency, renal failure, or end stage renal disease (ESRD). B. Record review The dialysis communication book was provided for Resident #75 on 3/25/25 at 2:17 p.m. by registered nurse (RN) #1. Review of the binder revealed one communication sheet, dated 3/17/25. The post dialysis section of the form was not completed by the facility staff. The assistant director of nursing (ADON) provided a second binder for Resident #75 on 3/25/25 at 2:58 p.m. Review of the second binder revealed the dialysis center information with chair time, resident face sheet, medical orders for scope of treatment (MOST) form and current medication list. Review of the communication forms in the binder revealed the following: -The 3/17/25 communication form was placed into this binder and was l missing the post dialysis section to be completed by the facility; -The 3/19/25 communication form did not have the post dialysis section completed by facility staff; -The 3/21/25 communication form did not have the post dialysis section completed by facility staff; and, -The 3/24/25 communication form did not have the post dialysis section completed by facility staff. The March 2025 CPO revealed the following physician's orders: Obtain vital signs pre dialysis and post dialysis every shift every Monday, Wednesday and Friday, ordered on 3/24/25. Fill out pre/post dialysis form for dialysis Monday, Wednesday and Friday, name of dialysis center, location and chair time, ordered on 3/26/25 (during the survey). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #75 had received four sessions of dialysis since admission to the facility. The facility failed to complete the post dialysis section of the communication form for all four dialysis sessions. III. Staff interviews RN #1 was interviewed on 3/25/25 at 3:06 p.m. She said the nurses were responsible for completing the dialysis communication forms prior to the resident leaving for dialysis and upon the resident's return. She said the nurse needed to review the form for orders or complications at dialysis and then complete the post dialysis section on the form. RN #1 confirmed the communication forms were incomplete (see record review above). The ADON was interviewed on 3/25/25 at 3:10 a.m. She said it was the floor nurses responsibility to ensure the dialysis communication forms were completed by all parties. The ADON said the missing entries on the dialysis forms were probably related to agency staff who provided care in the facility. The director of nursing (DON) was interviewed on 3/27/25 at 1:41 p.m. She said the facility was responsible for completing two of three sections on the communication forms used between the facility and the dialysis center. The DON said it was the responsibility of the floor nurse assigned to the resident to ensure the form was completed by all parties. The DON said the communication forms were important so the facility and the dialysis center were aware of the residents medical needs like if there was a change in condition or recommendations from dialysis to be discussed with the attending physician. The DON said agency staff have to review a binder prior to working to ensure they understand our policies, however it was the responsibility of the facility staff to ensure the forms were completed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40960 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five of five certified nurse aides (CNA). Specifically, the facility failed to complete annual performance reviews for CNA #2, CNA #4, CNA #5, CNA #6 and CNA #7 in order to determine potential training needs. Findings include: I. Facility policy and procedure The Performance Evaluations policy and procedure, revised September 2024, was provided by the regional director of clinical services (RDCS) on 3/27/25 at 1:22 p.m. It read in pertinent part, The job performance of each employee shall be reviewed and evaluated at least annually. A performance evaluation will be conducted on each employee at the conclusion of his/her 90 day probationary period, and at least annually thereafter. Performance evaluations may be used in determining employee's promotion, shift/position transfer, demotions, terminations, wage increases and to improve the quality of the employee's work performance. The written performance evaluations will contain the director's and/or supervisor's remarks and suggestions, any action that should be taken (further training), and goals. II. Record review Annual performance reviews were requested on 3/25/25 at 3:59 p.m. for CNA #2 (hired 7/20/23), CNA #4 (hired on 7/30/23), CNA #5 (hired on 7/20/23), CNA #6 (hired on 7/20/23) and CNA #7 (hired on 3/18/24). -The facility was unable to provide documentation indicated CNA #2, CNA #4, CNA #5, CNA #6 and CNA #7 had annual performance evaluations. -The director of nursing (DON) said the five CNAs did not have annual performance reviews and had not completed annual in-service education based on the outcome of their reviews. Cross-reference F943 for failure to ensure all staff had abuse and dementia training. III. Staff interviews (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 3/26/25 at 2:11 p.m. The DON said she had become the DON six weeks prior to the survey. She said she did not know why the annual performance evaluations had not been completed.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure residents diagnosed with mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing for one (#78) of three residents out of 17 sample residents. Specifically, the facility failed to: -Ensure Resident #78, who had a history of suicide attempts and trauma, was monitored for signs and symptoms of suicidal ideation; and, -Ensure Resident #78, who had a diagnosis of depression and requested to see a therapist, was provided with mental health services. Findings include: I. Resident #78 A. Resident status Resident #78, aged 66, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included multiple fractures of ribs, myocardial infarction (heart attack), diabetes, chronic kidney disease, adjustment disorder with depressed mood and compression fracture of vertebra. The 3/25/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident's depression screen assessment, dated 3/25/25, revealed Resident #78had indicated she felt depressed, hopeless and bad about herself. B. Resident interview and observation Resident #78 was interviewed on 3/24/25 at 11:00 a.m. Resident #78 said she was recently admitted to the facility following a car accident. She said she had asked the social services director (SSD) if she could see a therapist because she felt she needed to talk to someone. Resident #78 said she had lost her mother a few months prior to her admission to the facility, the anniversary of her nephew's murder was coming up in a few days and she was worried she would no longer be able to care for herself without assistance. She said she had not heard anything from the SSD about a therapist appointment. During the interview, Resident #78 became tearful and cried frequently when discussing her traumatic experiences. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The trauma informed care plan, initiated 3/21/25, revealed Resident #15was at risk for decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills and poor impulse control. Trauma included family issues, loss of mother in December 2024, murder of nephew in March 2022, life threatening illness, suicide attempt by overdose and recent breakup with her longterm partner. Interventions included encouraging the resident to verbalize her feelings, monitoring for signs and symptoms of decreased psychosocial wellbeing and adjustment issues and social services visits as indicated. Review of Resident #78's March 2025 CPO revealed the following physician's orders: Psychological evaluation and treatment needed, ordered 3/18/25. Bupropion (Wellbutrin) 150 milligrams (mg) tablet. Give one tablet by mouth one time per day for depression, ordered 3/18/25. Escitalopram (Lexapro) 5 mg tablet. Give one tablet one time per day for depression, ordered 3/18/25. Behavior monitoring for tearful or sad expressions, ordered 3/19/25. -The March 2025 CPO did not include a physician's order to monitor for potential signs and symptoms of suicidal ideation. The social history admission assessment, dated 3/18/25, revealed Resident #78 had indicated a history of stressful events to include a motor vehicle accident, life threatening illness or injury and a sudden, violent death. The resident lived with her sister and neither had been managing their health. Her sister was currently in the hospital and on dialysis. The discharge plan was unclear and the resident might have to move in with her brother. Social history obtained from the brother revealed the brother had concerns about the sisters being able to live together. Social services focus was to connect the resident with mental health services. Review of Resident #78's progress notes, from 3/18/25 to 3/25/25, failed to reveal documentation that referral had been sent to a psychologist for evaluation and treatment of the resident. II. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/26/25 at 9:09 a.m. LPN #1 said Resident #15 exhibited signs of depression, such as staying isolated in her room. LPN #1 said she knew the resident had lost her mother recently, but she was unaware of any other significant traumatic events or a history of suicide attempts for the resident. She said if the resident expressed signs or symptoms of depression, the nurse would document the information in the resident's medical record. Certified nurse aide (CNA) #2 was interviewed on 3/26/25 at 9:37 a.m. CNA #2 said he knew Resident #78's nephew had been murdered and the anniversary of his death was coming up. He said he was unaware of any other significant traumatic events or a history of suicide attempts for the resident. He said if the resident expressed signs or symptoms of depression, he would document it. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 was interviewed on 3/26/25 at 12:47 p.m. CNA #3 said Resident #78 cried frequently but she did not know why. The SSD was interviewed on 3/27/25 at 11:00 a.m. The SSD said she met with residents three days after admission to the facility. She said if a resident was having difficulty with coping or suffering from loss, she would check in with the resident. She said social services assessments were used to determine residents' needs. The SSD said the facility did not have any mental health providers. She said she only set up mental health services for a resident to follow up on after discharge from the facility. She said a resident with six or more traumatic events would be at higher risk for psycho social distress. She said if a resident had a history of suicidal ideations or attempts, that would warrant establishing behavior monitoring of signs and symptoms of increased depression. The SSD said she had completed a trauma assessment for Resident #78 and she was aware she had attempted suicide in the past. The SSD said she did not initiate behavior monitoring for suicidal ideations for the resident because Resident #78 said she would not attempt suicide again. She said she did not notify the facility staff that the resident had significant trauma or a history of suicide attempts. The SSD said it would be important for the staff to be aware that Resident #78 was at higher risk due for suicide due to an increase in stressors since her prior suicide attempt and staff could report to the SSD right away if there was a concern.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on observations, record review and interviews the facility failed to ensure for one (#5) of two residents reviewed received foods in the appropriate form as prescribed by the physician and/or assessed by the interdisciplinary team to support the treatment and plan of care. Specifically, the facility failed to consistently follow the physician's order for a renal diet for a Resident #5. Findings include: I. Professional reference The National Kidney Foundation (2023) Potassium in Your Diet, was retrieved on 4/2/25 from https://www.kidney.org/kidney-topics/potassium-your-ckd-diet It read in pertinent part, People with kidney disease are often advised to avoid high potassium foods. The body uses the potassium it needs. A person's kidneys remove the extra potassium from the blood. But when someone has kidney disease, the kidneys cannot remove extra potassium in the right way, and too much potassium can stay in the blood. When there is too much potassium in the blood, it is called hyperkalemia, or high potassium. Having too much potassium in the blood can be dangerous. Potassium affects the way a person's heart muscles work. When there is too much potassium, the heart may beat irregularly, which in the worst cases can cause heart attack. Foods high in potassium can include potatoes and tomatoes. II. Resident status A. Resident #5 Resident #5, age 80, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnosis of acute kidney failure, diabetes and protein calorie malnutrition. The 3/14/25 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. The resident had a diagnosis of renal failure and was prescribed a therapeutic diet. B. Resident interview and observation Resident #5 was interviewed on 3/24/25 at 10:30 a.m. She said she was not aware she had kidney disease until her recent hospitalization but tried to adhere to her new renal diet. Resident #5 said she was aware she was supposed to eat foods low in potassium but frequently received foods that were not consistent with her renal diet like potatoes, tomatoes and bananas. She said she left those items on the plate and did not eat them. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 1:00 p.m. Resident #5 had her lunch tray. She had received tomatoes on the side and she had left them uneaten. C. Record review The nutrition care plan, initiated 3/15/25, revealed the resident had altered nutrition related to acute kidney failure. Interventions included to provide diet as ordered. -The care plan did not specify the resident's therapeutic diet. The March 2025 CPO revealed a physician's order for a renal protein 80 gram (g) diet with regular textures- ordered on 3/10/25. The dietary assessment, dated 3/10/25, revealed the resident was on a renal diet and was cognitively able to understand her prescribed diet. The physician's history and physical, dated 3/10/25, revealed the resident was hospitalized prior to admitting to the facility due to her kidney functioning. She reported to the physician she had lost her sense of taste but it had improved with her improving renal function. The weight note, dated 3/19/25, revealed the resident had a 4% anticipated weight loss due to diuretics. The resident reported she did not eat a lot of her meal if she received foods that she knew were high in potassium. The resident was provided education on her diet. III. Staff interviews The nutrition service manager (NSM) and the registered dietitian (RD) were interviewed together on 3/27/25 at 10:30 a.m. The RD said she reviewed the resident's prescribed diet in her evaluation and put the diet order into the electronic medical record (EMR). The RD said the NSM was notified through the EMR and entered the diet order into the electronic ticket system. The RD said the electronic ticket system printed out the resident's meal tickets with their imputed diet, texture and preferences. The RD said she worked at the facility part time and when she was in the building, she checked the tickets on the meal trays before the tray went out to the resident to ensure the order was correct and consistent with the resident's diet. The RD said for a resident on a renal diet, they received foods that were low in potassium because of the kidney's compromised functioning. The NSM said the facility started using the current electronic ticket system two months prior and he had found occasional errors in the system if too many specifics are entered into a resident's diet order. He said he had been working on how to improve the system errors and on a process to provide education to the kitchen staff on the different therapeutic diets. He said he was aware of the error with the tomatoes on the meal tray for Resident #5 on 3/24/25 but was not aware she had received high potassium foods on other days. The NSM said he would begin to work on a system to make sure the tickets are checked for accuracy for every meal, not only the meals when the RD was present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection. Specifically, the facility failed to: -Ensure staff wore the appropriate personal protective equipment (PPE) in contact and/or droplet precaution resident rooms; -Ensure housekeeping staff cleaned resident rooms in a sanitary manner: and, -Ensure disinfectant dwell times were followed. Findings include: I. PPE failures A. Facility policy and procedure The Infection Preventions and Control Program, revised October 2018, was received from the regional director of clinical services (RDCS) on 3/24/25 at 2:23 p.m. It revealed in pertinent part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program is a facility-wide effort involving all disciplines and indi-viduals and is an integral part of the quality assurance and performance improvement program. B. Observations On 3/24/25 at 12:04 p.m. resident room [ROOM NUMBER] was observed to have a sign on the door identifying the room was on droplet precautions and a PPE container was located to the left of the door. The assistant director of nursing (ADON) was applying a gown, mask, gloves and a face shield. The ADON applied PPE prior to entering the resident room with a lunch tray. The ADON exited room [ROOM NUMBER] with a mask and face shield. The ADON then removed her face shield and placed it into a blue paper bag located on the isolation cart and performed hand hygiene with an alcohol based rub. The blue paper bag was noted to have a second face shield in it. -The ADON failed to dispose of the face shield or disinfect it prior to placing it into the blue paper bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/25 at 10:21 a.m. an unidentified housekeeper was observed cleaning resident room [ROOM NUMBER]. The room had a sign on the outside of the door indicating the resident was on droplet precautions and an isolation cart with PPE was available outside the door in the hallway. The housekeeper entered the resident's room wearing a surgical mask and gloves. Upon her exit from the isolation room she removed her gloves and completed hand hygiene with an alcohol based hand rub. She then proceeded to the next room with the surgical mask in place. The housekeeper was observed to enter two other resident rooms with the same surgical mask worn in room [ROOM NUMBER], who was on droplet precautions per the signage on the door. -The housekeeper failed to properly apply the correct PPE when entering a resident room in isolation for droplet precautions and she failed to remove all PPE on exit of the room. On 3/25/25 at 12:09 p.m. the nutrition service manager (NSM) was brought a lunch meal tray to residents in room [ROOM NUMBER]. He came to the closed door, read the sign and looked for the PPE cart. The NSM asked the floor nurse where the PPE was to enter room [ROOM NUMBER]. Registered nurse (RN) #1 advised him it had been moved into the resident's room. The NSM then placed the room tray items on a table in the hallway approximately 10 feet from the resident's room. The NSM entered the resident's room, collected a gown, gloves and a mask. He applied the PPE then walked across the hallway to retrieve the lunch tray and entered room [ROOM NUMBER] to deliver the room tray. -The NSM failed to properly don PPE without bringing the PPE into the hallway after entering the resident room to retrieve the PPE. On 3/25/25 at 2:38 p.m. an unidentified oxygen supplier entered resident room [ROOM NUMBER]. There was a sign on the door that indicated the resident was on droplet precautions. There was a cart to the left of the door that contained PPE. The unidentified oxygen supplier did not put on PPE. He was observed to be within three feet of the resident assessing her oxygen use. The oxygen supplier exited the room, returned to the nurses station, spoke with facility personnel, returned to the resident's room and had staff assist him in retrieving an oxygen concentrator from the resident's room that was not in use. He then applied gloves in the hallway and wiped the oxygen concentrator down with a disinfectant wipe. He left the concentrator in the hallway then proceeded to several other resident rooms reviewing their oxygen needs. -The oxygen supplier failed to apply PPE prior to entering an isolation room and failed to perform hand hygiene after exiting a resident's room who was on droplet isolation room. C. Staff interviews RN #1 was interviewed on 3/25/25 at 2:22 p.m. She said the resident in room [ROOM NUMBER] was on isolation for vomiting and loose stools. RN #1 said the resident in room [ROOM NUMBER] was able to self ambulate to the restroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 said the PPE cart was placed into the resident's room who resided in room [ROOM NUMBER] per the infection preventionist (IP) direction on 3/25/25. RN #1 said the IP informed her it could be placed inside the residents room if kept in what the facility considered a clean area in the room. RN #1 said the resident in room [ROOM NUMBER] was initially placed on droplet precautions, but was then changed to contact precautions per the IP direction. RN #1 said PPE was to be applied prior to entering the resident's room and removed prior to exiting. RN #1 said a gown and gloves were needed for contact precautions. RN #1 said if the resident was on droplet precautions the staff would have to apply a mask in addition to gown and gloves. RN #1 said regardless if the staff was providing care or not, anyone who entered a resident's room needed to apply PPE to prevent the spread of infection. The unidentified oxygen supplier was interviewed on 3/25/25 at 2:48 p.m. He said he worked for the oxygen company. He said he did not realize he entered a resident's room who was in isolation. He said he did not touch the resident, but should have performed hand hygiene on exit from the room. He said he usually applied PPE when he saw a sign on resident doors but did not apply it today. The infection preventionist (IP) was interviewed on 3/27/25 at 10:49 a.m. She said there were currently two residents in the building that were on isolation. She said one resident was on droplet precautions and the other one was on contact precautions. The IP said anyone who entered a room on droplet precautions needed to apply gloves, gown, mask and a face shield. The IP said anyone who entered a resident's room that was on contact precautions needed to apply a gown and gloves. The IP said PPE was important to help prevent the spread of infection. The IP said PPE could be stored inside a resident's room for contact precautions. She said PPE was stored outside of the room when the resident was on droplet transmission. The IP said they created a clean area within resident room [ROOM NUMBER] to place the PPE for contact isolation. She said she expected staff to enter the room to apply PPE in the deemed clean area within the room. The IP said a resident in room [ROOM NUMBER] was initially placed on droplet precautions by staff and when she arrived at the facility on 2/25/25. She said she reviewed the resident's isolation precautions and changed the precautions to contact based on the resident's symptoms. The IP said she then changed the signs and placed the isolation cart inside the resident's room. The IP said the facility had plenty of PPE and the face shield used on 3/24/25 should have been disposed of or wiped down with a disinfectant prior to being placed into the blue paper bag. The housekeeping laundry manager (HLM) was interviewed on 3/27/25 at 12:21 a.m. He said the housekeeping staff were to wear PPE when entering a resident room who was in isolation along with performing hand hygiene with soap and water. The HLM said alcohol based had rub could be used for hand hygiene, but soap and water was more effective. II. Housekeeping failures A. Professional Reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 4/2/25 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 4/2/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. The Profect HP Hydrogen Peroxide Disinfectant product specification sheet, undated, was retrieved on 4/2/25 from https://www.spartanchemical.com/globalassets/sharepoint/product-literature--documentation---epi documents/product-literature/l1008_profect_hp.pdf. It revealed in pertinent part Use Profect HP daily as part of a simple and effective cleaning and disinfection program for your entire facility on hard, non-porous surfaces. Featuring patented hydrogen peroxide technology, Profect HP kills bacteria and viruses in 60 seconds. One minute contact times ensure efficacy and compliance for your most critical disinfection needs. Ideal for daily use on high-touch surfaces, Profect HP is available in a convenient ready-to-use formula. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Routine Cleaning and Disinfection policy and procedure, undated, was received from the RDCS on 3/27/25 at 1:22 p.m. It revealed in pertinent part It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge. Cleaning considerations include, but not limited to, the following: a. Dry cleaning procedures will be conducted before wet procedures; b. Clean from areas that are visibly clean and least likely to be contaminated to areas usually visibly dirty; c. Clean from top to bottom (bring dirt from high levels down to floor levels); and, d. Clean from back to front areas. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: toilet flush handles; bed rails; tray tables; call buttons; TV (television) remote; telephones; toilet seats; monitor control panels, touch screens and cables; resident chairs; IV poles; blood pressure cuffs; sinks and faucets; light switches; and, door knobs and levers. Disinfectant solutions will be prepared fresh daily and changed frequently in order to ensure effectiveness. a. Follow manufacturer recommendations for dilution and frequency of changing of disinfectant solution. b. Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection. c. Change solution after cleaning a room under transmission-based precautions. Clean and disinfect any equipment that enters the room before use in another location. d. Verify products used to clean and disinfect surfaces in rooms under transmission-based precautions are effective against the pathogen of concern. C. Observations Housekeeper (HK) #1 was observed on 3/25/25 at 9:40 a.m. cleaning resident room [ROOM NUMBER], a single occupancy room. HK #1 performed hand hygiene with alcohol based hand rub and applied gloves. She entered the room with Profect HP disinfectant spray and a rag. HK#1 sprayed a table in the room, the TV stand and dresser tops. HK#1 immediately wiped the spray on the surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HK #1 failed to allow a one minute dwell time for the Profect HP disinfectant to sit on the surface of items to ensure it was properly disinfected (see professional reference above). HK#1 removed her gloves, performed hand hygiene with alcohol based hand rub and applied new clean gloves. HK #1 then entered the bathroom with Profect HP disinfectant spray and two rags. HK #1 sprayed the sink handles, rim and bowl then she sprayed the toilet tank, rim and bowl with Profect HP disinfectant spray. HK #1 immediately flushed the toilet after she sprayed it with Profect HP disinfectant. HK #1 then returned to the sink and turned on the water. She splashed water onto the mirror and took a paper towel from the paper towel and wiped the mirror. HK#1 then took one rag and wiped the sink rim, handles and then the bowl of the sink. HK #1 then took the same rag she cleaned the sink with and wiped down all the grab bars in the bathroom. -HK #1 failed to clean the sink from cleanest to dirtiest. -HK #1 used the same rag, which had been contaminated by the sink, to clean the grab bars which were not sprayed with any Profect HP disinfectant spray. HK #1 went to the toilet with a new rag and she wiped the toilet tank, the handle, the seat and the rim of the toilet bowl. HK #1 then took the rag, dunked it into the toilet bowl water, wrung out the rag splashing water outside of the toilet. She then wiped the rim of the toilet again and the outside of the toilet to the floor with the same rag she dipped into the toilet bowl. -HK #1 failed to clean the toilet in a hygienic manner. HK#1 then returned to her cleaning cart. She removed her gloves, performed hand hygiene with alcohol based rub and applied clean gloves. She collected two mop pads from a bucket on her cart and wrung them out. HK #1 took one mop pad to clean the resident room from the window to the bathroom door. She changed the mop pad out and used the second mop pad in the bathroom. She used the same mop mad to clean the and the remaining floor from the bathroom door to the entrance of the room. -HK#1 failed to clean the floor in a hygienic manner as she finished mopping the room with the same mop pad from the bathroom. HK#1 said she was done cleaning room [ROOM NUMBER] at 9:51 a.m. -HK #1 failed to clean high touch areas in a resident room like call light, bed controls, handles to dresser, handles to doors and the bedside table. HK#1 was observed to clean room [ROOM NUMBER], a single occupancy room, on 3/25/25 at 9:54 a.m. She performed hand hygiene with alcohol based rub and applied clean gloves. HK #1 entered the resident's room with rag and Profect HP disinfectant spray. HK #1 sprayed the disinfectant on the horizontal surfaces of the TV stand, dresser, bedside table, night stands and tops of lamps. While HK #1 was spraying disinfectant spray she moved items that were on the bedside table including the resident's urinal. HK#1 immediately wiped the surface after spraying with disinfectant. The surfaces did not remain wet for one minute. -HK #1 failed to clean handles to dresser, night stand, call lights, bed controls and light switches. HK #1 failed to keep surfaces wet with disinfectant for one minute dwell time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #1 returned to the cleaning cart, removed her gloves, performed hand hygiene with alcohol based hand run and applied new clean gloves. HK #1 then collected two rags and entered the resident's bathroom. HK #1 sprayed disinfectant spray on the paper towel dispenser and the sink. HK #1 took one rag and wiped the paper towel dispenser. With the same rag, she wiped the sink rim and sink handle. HK #1 splashed water onto the mirror and wiped it down with a paper towel. HK #1 wiped the sink bowl and. Using the same rag she wiped down the grab bars in the bathroom without spraying them with a disinfectant. -HK #1 failed to clean the bathroom sink and grab bars in a hygienic manner. HK #1 did not apply any disinfectant to the grab bars prior to wiping them down with the solid rag from the sink. HK #1 took a second rag and began wiping the toilet by wiping the tank, handles, seat, and the rim of the toilet bowl . HK #1 then dunked the rag into the toilet bowl water and rang it out. She splashed toilet bowl water on the outside of the toilet. Using the same rag she wiped the toilet rim and the outside of the toilet base to the floor. -HK #1 failed to clean the toilet in a hygienic manner. HK #1 said she had completed cleaning the resident room at 10:09 a.m. -HK#1 failed to clean the high touch areas in the resident room: call light, door handles, light switches. D. Staff interviews HK #1 was interviewed on 3/25/25 at 10:10 a.m. She said the disinfectant spray she used was called Profect HP and had a three minute dwell time. -However, according to the manufacturer recommendations the dwell time was one minute (see manufacturer recommendations above). HK #1 said high touch areas in a resident room were cleaned only during a deep cleaning or when the resident was discharged from the facility. HK #1 said high touch areas were call lights, bed controls, light switches, handles and door handles. HK #1 said she did not clean the high touch areas as the two rooms she cleaned were regular cleans and not deep cleans. HK #1 said she had a toilet bowl brush to clean toilets but only used it when there was visible stool observed in the toilet. HK #1 said the Profect HP disinfectant she sprayed on the toilet was enough to clean it. She said she had no concerns with wiping the rim and the outside part of the toilet after dipping the rag into the toilet bowl. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The housekeeping and laundry manager (HLM) was interviewed on 3/27/25 at 12:21 a.m. with the director of nursing (DON) present. The HLM said the chemicals used in the facility had a one to two minute dwell time. He said the surface had to remain wet for it to be effective in disinfecting the surface. The HLM said high touch surfaces were to be cleaned daily due to them being frequently touched by residents or staff. The HLM said high touch areas in resident rooms included call lights, door knobs and remotes. The HLM said the residents' rooms should be cleaned in a clock manner to ensure all surfaces were cleaned accordingly. The HLM said areas should be cleaned from cleanest to dirtiest areas to prevent contamination of cleaner areas. The IP was interviewed on 3/27/25 at 10:49 a.m. The IP said high touch areas in a resident's room included bedside tables, handles to drawers or doors, call lights, light switches, bed controls and any area the resident frequently touched. The IP said the high touch area should be cleaned daily with a disinfectant to help prevent the spread of infection. The IP said when cleaning a room, the cleanest areas should be cleaned first then the dirtiest last to prevent moving contamination from a dirtier area to cleaner areas. The IP said she did not know what disinfectant spray the housekeepers used to clean rooms. The IP said dwell time meant the time the surface was to remain wet for the disinfectant to be effective.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40960 Based on record review and interviews, the facility failed to provide training to their staff that at a minimum educated staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident dementia abuse prevention. Specifically the facility failed to: -Provide annual resident abuse prevention training to 17 out of 74 staff members; and, -Provide annual dementia management training for 15 out of 74 staff members. Findings include: I. Facility policy and procedure The Training Requirements policy and procedure, undated, was provided by the regional director of clinical services (RDCS) on 3/31/25 at 9:22 a.m. It read in pertinent part, It is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement and volunteers consistent with their expected roles. II. Staff training records A request was made for the facility's annual abuse and dementia training records for all active staff members on 3/25/25. On 3/26/25 at 11:00 a.m the RDCS provided the records for all active staff members who had completed annual abuse and dementia training. She said the training had not been completed by all the facility staff. Additionally, the records revealed 17 out of 74 staff members had not completed the facility's annual abuse training and 15 out of 74 had not completed the facility's annual dementia training. -The facility failed to ensure all active staff members completed the annual training for abuse and dementia. III. Staff interviews The director of nursing (DON) was interviewed on 3/26/25 at 2:11 p.m. The DON said she had become the DON six weeks prior to the survey. She said abuse and dementia training were completed upon hire and annually by human resources. She said she was responsible for tracking the staff abuse and dementia training and did not know why the training had not been completed.