STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065402	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neurorestorative Colorado	5945 S Wright St Littleton, CO 80127

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure accurate assessments, informed risks, and ongoing monitoring was in place for three (#1, #13 and #6) of six residents with bed rails out of 20 sample residents. Specifically, the facility failed to: -Ensure risks of bed rails were explained to Resident #1 or the resident' s representatives prior to the initiation of the bed rails; -Ensure bed rail assessments were accurately completed for Resident #1, Resident #6 and Resident #13; -Ensure consent was obtained for the use of a bed rail from Resident #1; and, -Ensure ongoing monitoring of bed rails in use was completed for Resident #1, Resident #6 and Resident #13. Findings include: I. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included surgical aftercare on the skin, pressure ulcers, traumatic subdural hemorrhage (brain injury where blood accumulates between the brain and its outermost covering) and emphysema (lung disease causing difficulty breathing). The 4/25/25 minimum data set (MDS) assessment revealed Resident #1 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He was dependent on staff for assistance with toileting, transfers and bathing, and needed supervision with upper body dressing and set up at mealtime. (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS assessment documented bed rails were not used. -However, observations revealed bed rails were being used (see observations below). B. Observations and resident interview Resident #1 was interviewed on 4/28/25 at 10:38 a.m. Resident #1 said he used the bed rails to pull himself up but did not use them to turn to his side. He demonstrated how he used the bed rails to reposition himself and pulled himself toward the head of the bed. There was a quarter length bed rail on each side of Resident #1' s bed. C. Record review Resident #1' s 11/8/24 admission bed rail assessment and 2/9/25 quarterly bed rail assessment documented that side rails or bed rails would not be used or considered for this resident. -However, Resident #1 had a quarter length bed rail on each side of his bed and stated he used the bed rails to reposition himself in bed. A review of Resident #1' s record did not include a consent for the use of a bed rail. Resident #1' s care plan, initiated 11/20/24, documented the resident was at high risk for falls due to an above the knee amputation, traumatic brain injury, weakness and paralysis. Pertinent interventions included to use side rails as ordered. -However, Resident #1 did not have a physician' s order or assessment for bed rail use (see observations above). II. Resident #13 A. Resident status Resident #13, age less than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included quadriplegia (a loss of function of the arms and legs), hypotension (low blood pressure), neuromuscular (system of nerves and muscles that enables voluntary movement) spinal cord injury, anxiety and major depressive disorder. The 2/21/25 MDS assessment revealed Resident #13 was cognitively intact with a BIMS score of 15 out of 15. He was dependent on assistance for all activities of daily living (ADL). The MDS assessment documented bed rails were not used. -However, observations revealed bed rails were being used (see observations below). B. Observations and resident interview Resident #13 was interviewed on 4/28/25 at 11:07 a.m. Resident #13 said he wanted the bed rail to support his water bottle and devices but did not use the bed rails to reposition himself. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was a quarter length bed rail on one side of Resident #13' s bed. C. Record review Resident #13' s 4/20/23 admission side rail assessment documented side rails bed rails would be considered for the resident and the rails were requested for attaching personal devices and were requested by the resident. -However, the remainder of the assessment was not completed to indicate if the resident was assessed for the use of the bed rails and the section that included risk factors was not completed. Resident #13' s 12/5/24 quarterly side rail assessment documented side rails or bed rails would be used or considered for this resident for access to water. Risk factors were documented on the assessment. Resident #13' s 3/6/25 quarterly side rail assessment documented side rails or bed rails would not be used or considered for this resident. -However, a quarter length bed rail was on Resident #13' s bed and used for water bottle support and personal devices (see observations above). Resident #13' s skin care plan, revised 12/2/24, documented Resident #13 had potential/actual impairment to skin integrity due to his immobility, healed skin graft and surgical wound. Pertinent interventions, initiated 5/2/23 and revised 7/19/24, included to pad bed rails, wheelchair arms or any other source of potential injury if possible. III. Resident #6 A. Resident status Resident #6, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included amyotrophic lateral sclerosis (ALS-a neurodegenerative disease), hand contractures (tightening of the hands), major depressive disorder, anxiety and high blood pressure. The 3/21/25 MDS assessment revealed Resident #6 was cognitively intact with a BIMS score of 15 out of 15. He was dependent on staff for assistance for bathing, and needed substantial assistance dressing and set up assistance only with bed mobility. The MDS assessment documented bed rails were not used. -However, observations revealed bed rails were being used (see observations below). B. Observations and resident interview Resident #6 was interviewed on 4/28/25 at 2:54 p.m. Resident #6 said he wanted the side rails on his bed to support his pillows. Resident #6 said he did not use the side rails to reposition himself. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was a quarter length bed rail on each side on Resident #6' s bed. C. Record review Resident #6' s 7/14/22 admission side rail assessment documented side rails bed rails were for increased mobility and the residents request. Resident #6' s 3/7/25 quarterly side rail assessment documented side rails or bed rails would not be used or considered for this resident. -However, Resident #6' s a quarter length bed rail was on Resident #6' s bed and used to support his pillows (see observations above). The remainder of the assessment was not completed and the section that included risk factors was not completed. V. Staff interviews Registered nurse (RN) #1 was interviewed on 4/30/25 at 1:55 p.m. RN #1 said nurses and certified nurse aides (CNA) did visual checks on the residents rooms but was not sure who checked the bed rails for functionality. The director of nursing (DON) was interviewed on 5/1/25 at 3:30 p.m. The DON said the facility contracted a vendor to check the beds at least annually but he was unsure if there was documentation that the bed rails were checked monthly or more frequently. The DON said the risks of the bed rails were communicated to the residents but he was not sure where that documentation was. The DON said that he and the assistant director of nursing (ADON) would manage the bed rail consents in the future and the director of rehabilitation (DOR) would also be involved. The DON said every resident was assessed for bed rails when they were admitted to the facility. The DON said that the assessment for Resident #1 should have had more information included on the assessment and that Resident #6 used his bed rails to prop his pillows and Resident #13 used the bed rail for his devices and water. VI. Facility follow up The nursing home administrator (NHA) provided a performance improvement plan (PIP) for bed rail use on 4/30/25 at 4:36 p.m. The documented issues included in the plan were side rail assessments were to be completed per policy and accurately on admission and quarterly, and bed rail consents would be in place and signed. The steps to be implemented and completed were: a complete audit of all residents was to be conducted for the side rail assessments to determine their accuracy; training provide to staff to ensure the assessment process was followed and accurate; a risk vs benefit documented signed by the resident and reviewed quarterly; the outside vendor bed evaluations will be documented when completed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 47151 Based on observations, record review and interviews, the facility failed to provide each resident with a nourishing, palatable and well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences for each resident. Specifically, the facility failed to: -Provide a balanced menu for residents; -Ensure Resident #5 received a variety of pureed dessert options; -Ensure international dysphagia diet standardization initiative (IDDSI) standards were utilized for production of IDDSI modified texture diet orders; and, -Ensure Resident #18 received a minced and moist level five texture diet instead of a pureed diet. Findings include: I. Professional reference The International Dysphagia Diet Standardization Initiative (IDDSI) minced and moist level five patient handout (2019) and retrieved 5/8/25, read in pertinent part, Meat is served finely minced or chopped to 4 millimeter (mm) lump size served in a thick, smooth, non-pouring sauce or gravy. Vegetables are cooked, finely mashed or use a blender to finely chop it into to 4 mm lump size pieces (drain any excess liquid). [NAME] requires a sauce to moisten it and hold it together. [NAME] should not be sticky or gluey and should not separate into individual grains when cooked and served; it may require a thick, smooth, non-pouring sauce to moisten and hold the rice together. II. Resident interviews Resident #1 was interviewed on 4/28/25 at 10:38 a.m. Resident #1 said he did not like the majority of the menu items offered and he did not always get what he had ordered. Resident #15 was interviewed on 4/28/25 at 11:36 a.m.Resident #15 said the menu primarily had chicken and hamburgers and he did not eat chicken so he ordered food from outside sources out a lot. Resident #13 was interviewed on 4/28/25 at 12:44 p.m. Resident #13 said the menu was too repetitive, the food was cooked poorly and did not look good. Resident #6 was interviewed on 4/28/25 at 2:54 p.m. Resident #6 said the menu was too repetitive from one week to the next. III. Resident group interview (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident group interview was conducted on 4/29/25 at 1:00 p.m. The group consisted of four residents (#13, #15, #4 and #18) who were interviewable based on assessment and the facility. The residents said they continued to have concerns about the food. Resident #1 said the menu was repetitive and he ate food from outside the facility frequently. Resident #4 said the menu was repetitive. IV. Resident council minutes The resident council minutes were provided by the nursing home administrator (NHA) on 4/29/25 at 2:30 p. m. The February 2025 minutes documented the residents would like more menu variety. The April 2025 minutes documented the residents would like to see less chicken. -Review of the February 2025 and April 2025 minutes did not reveal documentation indicating the facility had addressed the residents' concerns. V. Record review The weekly menu served from 4/27/25 to 5/3/25 (during the survey) was provided by the nursing home administrator (NHA) on 4/29/25 at 3:46 p.m. A review of the menu revealed the following: -Chicken was served as the entree for dinner on 4/28/25 and again for lunch on 4/29/25; -Rice was served as a side for dinner on 4/28/25, as a side and part of the entree for lunch on 4/29/25 and as a side for dinner on 5/2/25. The recipes for the 4/30/25 noon meal were provided by the NHA 4/30/25 at 6:12 p.m. The lunch meal on 4/30/25 was lazy stuffed peppers, spring fruit cup, green salad and mushroom rice. The recipes documented the following texture modifications: -Spring fruit cup puree diet: replace with mandarin oranges and process until smooth. Food should be smooth with no lumps and cohesive enough to hold its shape. -Lazy stuffed pepper dysphagia special diet instructions - puree to a smooth texture that holds shape with no lumps. The recipes failed to include diet modification for the minced and moist level five IDDSI diet prescribed to Resident #18 (see meal service observations below). VI. Dining observations 1. Resident #5 (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 12:02 p.m Resident #5 received a pureed lunch that included a pureed entree, side dish, apple sauce and chocolate pudding. On 4/30/25 at 12:20 p.m. Resident #5 received a pureed lunch that consisted of pureed stuffed peppers, pureed green vegetable, apple sauce and vanilla pudding. On 4/30/25 at 5:12 p.m. Resident #5's received his dinner, which consisted of pureed pork roast, pureed vegetable medley, pureed au gratin potatoes, apple sauce and chocolate pudding. -A review of Resident #5's April 2025 CPO revealed a physician's order for a pureed diet. Resident #5 received applesauce and pudding at all three meals instead of a variety of desserts, including the pureed mandarin oranges in the puree diet modification for the lunch meal on 4/30/25 (see recipes above). 2. Meal service observation During a continuous observation on 4/30/25, beginning at 11:55 a.m. and ending at 12:18 p.m., the following was observed during meal preparation and service in the kitchen: At 11:58 a.m. Resident #18's lunch plate was assembled by cook (CK) #2 with pureed lazy stuffed peppers and pureed vegetables, applesauce and pudding. The meal ticket on the tray documented a minced and moist level five diet order and the tray was placed on the cart for delivery. -Resident #18's lunch on 4/30/35 was pureed using the instructions from the recipe and not prepared utilizing the standards of the IDDSI (see professional reference above) that included minced food items instead of pureed items. On 4/30/25 at 5:15 p.m. Resident #18 was eating dinner in his room. Resident #18's dinner consisted of ground pork roast without a sauce or gravy and chopped vegetables (see professional reference above). Resident #18 was interviewed on 4/30/25 at 5:15 p.m. Resident #18 said his food was pureed at lunch and used to have his food more blended. VII. Staff interviews CK #1 and CK #2 were interviewed on 5/1/25 at 12:45 a.m. CK #1 said he had been trained on modified textures. CK #1 said he was provided verbal training that included instructions on what residents could or could not have based on their diet order. CK #1 and CK #2 said they did not have diet spreadsheets or recipes that included IDDSI minced and moist level five modifications or puree specification. The director of nursing (DON) was interviewed on 5/1/25 at 4:30 p.m. The DON said the facility utilized IDDSI diets. The DON said a floor nurse would enter a prescribed diet and a registered dietitian would do an initial nutrition assessment upon admission. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 5/1/25 at 4:30 p.m. The NHA said the staff had dysphagia training as part of the facility's online training but was unsure if IDDSI was included in the training. The quality director (QD) was interviewed on 5/1/25 at 5:00 p.m. The QD said the facility used a menu program but was unsure if all the IDDSI resources were included in the menu program. The QD said the facility had used IDDSI diets for approximately a year. 50690

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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. 47151 Based on observations, record review and interviews, the facility failed to ensure residents on a pureed diet out of 20 sample residents received food and fluids prepared in a form designed to meet his or her needs. Specifically, the facility failed to ensure residents who were prescribed pureed texture diets were served food that was prepared according to their diet order as indicated on their meal tray cards. Findings include: I. Professional reference The International Dysphagia Diet Standardization Initiative (IDDSI) Pureed Audit Tool (September 2020) retrieved 5/6/25 read in pertinent part, Critical appearance of pureed food: no lumps, food slides smoothly and easily between fingers. A puree needs to be able to be put in the mouth and swallowed whole. No chewing and no bolus (a soft mass of chewed food) formation skills should be needed to eat this. II. Meal observation During a continuous observation on 4/30/25, beginning at 11:55 a.m. and ending at 12:18 p.m., the following was observed during the meal preparation and service in the kitchen: The posted menu was lazy stuff pepper, green salad, spring fruit cup and mushroom rice. At 11:55 a.m. a resident's lunch plate was assembled by cook (CK) #2 with pureed lazy stuffed pepper and pureed vegetables. The meal ticket on the tray documented a puree texture and the tray was placed on the cart for delivery. At 11:56 a.m. another resident's lunch plate was assembled by CK #2 with pureed lazy stuffed pepper and pureed vegetables. The meal ticket on the tray documented a puree texture and the tray was placed on the cart for delivery. -Both pureed meals had visible lumps in the pureed entree and pureed vegetables. III. Test tray A test plate for a pureed lazy stuffed peppers entree was evaluated by two surveyors immediately after the last resident had been served their lunch meal on 4/30/25 at 12:19 p.m. The pureed entree had visible lumps and pieces of red pepper. The pureed entree was not smooth and required chewing. IV. Record review (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The recipes for the 4/30/25 noon meal were provided by the nursing home administrator (NHA) 4/30/25 at 6:12 p.m. The recipes documented the pureed modifications of food items served during lunch meal service on 4/30/25 as follows: food should be smooth with no lumps and cohesive enough to hold its shape on the spoon. V. Staff interviews CK #1 and CK #2 were interviewed together on 5/1/25 at 12:45 p.m. CK #1 said modified textured diets were for residents who had difficulty chewing or swallowing. CK #1 said the risk of a modified texture not being produced correctly could cause a resident to choke or pocket food. CK #2 said he checked his puree textures before meals and was not expecting the rice in the lazy stuffed peppers to clump up like it did that day. The director of nursing (DON) and the NHA were interviewed together on 5/1/25 at 4:30 p.m. The DON said if he or any other staff observed food not prepared correctly in the past they have asked the kitchen staff to remake the item and the cooks were willing to remake it. The NHA said facility staff did receive training on swallowing and dysphagia but was unsure if it contained information on IDDSI textures. The quality director (QD) was interviewed on 5/1/25 at 5:00 p.m. The QD said the facility used a menu program but was unsure if all the IDDSI resources were included in the menu program. The QD said the facility had used IDDSI diets for approximately a year.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47151 Based on observations, record review and interviews, the facility failed to store, prepare and distribute food in a sanitary manner in the main kitchen and nourishment refrigerator/freezer. Specifically, the facility failed to ensure time and temperature control food was labeled, dated and disposed of timely. Findings include: I. Professional reference The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/6/25 read in pertinent part, Commercially processed food: open and hold cold, refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, the day the original container is opened in the food establishment shall be counted as day one and the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (3-501.17) II. Record review The refrigerated storage chart, undated, was provided by the nursing home administrator on 5/1/25 at 5:12 p. m. The chart recommended the maximum storage period for unopened ham and unopened luncheon meats was five days. -The chart did not include a recommended maximum storage period for opened product or soft cheeses (see below). III. Observations The initial main kitchen tour was conducted on 4/28/25 at 9:15 a.m. The following was observed: -A clear plastic container with a lid that contained broccoli and carrots in liquid was not marked with a label or date. -A clear plastic bag that contained an opened package of sliced deli turkey had a written date in black marker of 4/10/25 on the bag. No expiration date was written on the bag. A freeze by date of 4/13/25 was printed on the package of turkey. -A clear plastic bag that contained an opened package of sliced deli honey ham that had a written date in black marker of 3/20/25. No expiration date was written on the bag. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A commercially processed raw turkey breast in the original wrapper with a date of 4/21 written in black marker on the wrapper. The instructions were to thaw in the refrigerator for one and a half to two days. -A clear plastic bag that contained an open package of sliced american swiss cheese. No date was written on the bag. On 5/1/25 at 10:25 a.m. the following items were observed in the nourishment refrigerator: 13 vanilla magic cups with use by date of 2/6/25 and 13 chocolate magic cups with a use by date of 4/10/25. On 4/30/25 at 11:35 a.m. the following was observed in the main kitchen: -A clear plastic bag that contained an opened package of sliced deli turkey had a written date in black marker of 4/10/25 on the bag. No expiration date was written on the bag. A freeze by date of 4/13/25 was printed on the package of turkey. -A clear plastic bag that contained an opened package of sliced deli honey ham that had a written date in black marker of 3/20/25. No expiration date was written on the bag. -A commercially processed raw turkey breast in the original wrapper with a date of 4/21 written in black marker on the wrapper. The instructions were to thaw in the refrigerator for one and a half to two days. -A clear plastic bag that contained an open package of sliced american swiss cheese; No date was written on the bag. IV. Staff interviews Cook (CK) #1 was interviewed on 5/1/25 at 12:45 p.m He said he did not know there were expiration dates on the bottom of the magic cups. CK #1 said he was not sure what expiration date to use for the opened sliced cheese and was unsure how long the turkey breast had been thawing in the refrigerator. CK #1 said the kitchen staff put a date on the original package of deli meat when it was received or frozen in the kitchen and an open date on the clear bag once the product was opened. CK #1 said he was unsure what expiration date to use. The quality director (QD) was interviewed on 5/1/25 at 5:00 p.m. The QD said the kitchen had a food storage guideline chart they should use for dating and labeling refrigerated food items.

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Neurorestorative Colorado	5945 S Wright St Littleton, CO 80127

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to implement their policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption. Specifically, the facility failed to: -Implement the facility policy for food brought by visitors and ensure food that was kept in resident's refrigerators had safe and sanitary storage; and, -Ensure the residents personal refrigerator temperatures were monitored correctly for appropriate temperatures. Findings include: I. Professional reference The Colorado Retail Food Regulations, ([DATE]) were retrieved on [DATE]. It read in pertinent part, Except during preparation, cooking, or cooling, time and temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less. (,d+[DATE].16) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (,d+[DATE].17) The Food and Drug Administration (FDA) food code ([DATE]) were retrieved on [DATE] from https://www.fda.gov/food/fda-food-code/food-code-2022 revealed in pertinent part, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone (41 degrees to 135 degrees F) too long. II. Facility policy and procedure The Food Brought Into Facility By Visitors policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 2:30 p.m. It read in pertinent part, All food brought to the facility residents by visitors will be checked by dietary or licensed personnel. Label food items brought in by visitor with resident's name, food content, date visitor brought item in and a use by' UB' date of one day out. Education on safe handling will be provided by trained dietary personnel or trained nursing staff to all family, residents, visitors and community groups who may provide foods or fluids to residents of the facility. This education will include at a minimum proper food handling to prevent foodborne illness, requirements for covered containers or secure wrapping, leftover foods will be discarded, method for checking proper food temperature (staff only). Perishable foods requiring refrigeration brought into the facility by a visitor for a resident, must be stored in a designated refrigerator and will be separate from the main facility kitchen storage area. The food must be stored in a (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	container and labeled with the resident's name, content, date brought into the facility and UB date. The resident refrigerator agreement form was received from the DON on [DATE] at approximately 11:30 a.m. It revealed the following: The expectations of the facility regarding upkeep of personal refrigerators, are understood; Education was provided on appropriate food storage temperatures for personal refrigerators; It is understood that patients and families are responsible for ensuring that food is kept at the appropriate temperature; and, Patients and families are responsible for cleaning their personal refrigerators on a regular basis or asking for assistance. III. Observations On [DATE] at 10:45 a.m., the inside of Resident #8's personal refrigerator had a large, light brown, dried liquid spill on the left side of the refrigerator shelves. There were two opened, half eaten four ounce (oz). containers of chocolate pudding were in the resident's refrigerator. The pudding was not labeled. On [DATE] at 2:54 p.m. a four oz container of commercially packaged yogurt was in Resident #6's personal refrigerator. The yogurt had a use by date of February 2025. On [DATE] at 12:10 p.m. Resident #8's personal refrigerator still contained two opened, half eaten four oz. containers of chocolate pudding. The items were not labeled. On [DATE] at 12:14 p.m. there were two containers, one of commercially packaged vanilla pudding and one yogurt in Resident #12's personal refrigerator. The vanilla pudding had an expiration date of [DATE]. The yogurt had an expiration date of [DATE]. IV. Resident interviews Resident #6 was interviewed on [DATE] at 2:54 p.m. Resident #6 said the facility staff would rotate the food in his personal refrigerator and tried to discard the food if it was old or expired. V. Staff interviews Certified nurse aide (CNA) #1 and was interviewed on [DATE] at 10:30 a.m. CNA #1 said there were no temperature logs at the nurses'station for the residents personal refrigerator. CNA #1 said the maintenance director checked the residents personal refrigerators. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 11:54 a.m. LPN #1 said that if a resident's personal refrigerator looked dirty on the inside, she went through the contents and cleaned it. She said she thought that housekeeping staff checked and cleaned the personal refrigerators every so often. She thought that the maintenance department kept track of the refrigerator temperatures. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 was interviewed on [DATE] at 2:54 p.m. LPN #2 said that staff members kept track of what was in the residents' personal refrigerators. She said she had never seen families maintain the refrigerators, just stock them. She said that the food/personal refrigerator policy was signed by the resident's family upon admission. The director of nursing (DON) was interviewed on [DATE] at 3:30 p.m. The DON said staff were to assist the residents in getting food products from their personal refrigerators if the resident needed assistance getting the product. The DON said he was unsure if a formal process was in place to check the resident's refrigerators. The nursing home administrator (NHA) was interviewed on [DATE] at 5:00 p.m. The NHA said the facility's process was that the resident was responsible for their personal refrigerator but housekeeping staff also checked the refrigerators. 50690

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50690 Based on observations, 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 development and transmission of disease on one of two units. Specifically, the facility failed to ensure enhanced barrier precautions (EBP) were followed during wound care for Resident #1. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC), Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO)'s, (4/2/24), retrieved on 5/5/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens changing briefs or assisting with toileting, device care or use (central line urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). II. Observations During a continuous observation of wound care on 4/29/25, beginning at 2:36 p.m. and ending at 2:55 p.m., the following was observed: An EBP sign was posted on the outside of Resident #1's door. Registered nurse (RN) #1 and RN #2 entered Resident #1's room. RN #1 and RN #2 washed their hands and donned (put on) gloves before beginning Resident #1's wound care. RN #1 provided wound care and dressing changes for Resident #1's two wounds while RN #2 assisted. -However, RN #1 and RN #2 failed to don gowns prior to providing wound care for Resident #1. III. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 and RN #2 were interviewed together on 4/29/25 at 3:00 p.m. RN #2 said that EBP was worn while doing tasks with a risk of getting wet, such as giving tube feedings and working with residents who had tracheostomies (an opening to the airway usually with a tube) and catheters. She said the personal protective equipment (PPE) requirements for EBP were similar to the PPE required for contact precautions. RN #1 said staff did not get training on EBP, but the former director of rehabilitation had put EBP signs on the doors of some residents and had PPE supplies placed in the halls. RN #1 said the former director of rehabilitation provided education regarding the new EBP signage to the staff who were working that shift when the signs were put up. However, she said any staff who was not working that shift, and any new staff, did not receive the EBP signage education. The director of nursing (DON) was interviewed on 5/1/25 at 12:32 p.m. The DON said EBP should be used for people with tracheostomies, catheters, central intravenous lines, or gastric tubes. He said gloves and gowns should be worn to do tracheostomy care or suctioning, catheter care, wound care, bathing, dressing, or doing big transfers with close contact for these residents. He said he had provided some education to staff and had printed more EBP education but had not gotten it out to staff yet. He said he had ordered racks for PPE supplies and had put PPE supply carts in the hallways.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal vaccinations for one (#5) of five residents out of 20 sample residents. Specifically, the facility failed to provide the pneumococcal vaccination to Resident #5. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2022, retrieved on 5/6/25, from https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, in pertinent part, For those over the age of 65 who meet age requirements and lack documentation of vaccination, or lack evidence of past infection was: One (1) dose PCV15 followed by PPSV23 or one (1) dose PCV20. II. Resident #5 A. Resident status Resident #5, over age 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included a history of intracranial injury and subdural hemorrhage (brain bleed), atrial fibrillation (abnormal heart rhythm), heart failure, legal blindness and benign prostatic hyperplasia (enlarged prostate gland). The 4/11/25 minimum data set (MDS) assessment revealed the resident had short term and long term memory problems and had severely impaired decision making per staff assessment. He required partial assistance with eating and dressing his upper body and moderate assistance for most transfers and dressing his lower body. He used a manual wheelchair for mobility. The assessment documented that the resident's pneumococcal vaccination was not up to date. He was offered the vaccination and declined it. -However, the resident's representative signed a consent form on 1/12/25 indicating the resident was to receive the pneumococcal vaccination. B. Record review A consent for the pneumococcal vaccination, dated 1/12/25, was signed by Resident #1's representative. -However, a review of Resident #1's electronic medical record (EMR) revealed no documentation that the resident had received the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's EMR did not reveal documentation indicating the resident declined the pneumococcal vaccination. III. Staff interview The director of nursing (DON), who was also infection preventionist (IP) #2, was interviewed on 5/1/25 at 1:30 p.m. The DON said that there was no record that Resident #1 received the pneumococcal vaccination. He said he would have had to order the serum, but that the resident still should have received it. He said he would research why it was not given and if the resident still wanted to receive the vaccination, he would order and administer it. LPN #2 was interviewed on 5/1/25 at 3:02 p.m. LPN #2 said whoever obtained consent for the pneumococcal vaccine, would be the one to put in the order. LPN #2 said the physician would authorize it and then the serum would be ordered from the pharmacy.