STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to provide reasonable accommodations necessary to accommodate mobility and accessibility in the resident's environment for one (#26) of one resident reviewed for accommodation of needs out of 53 sample residents. Specifically, the facility failed to ensure Resident #26's bed side rails were installed as requested by the resident and as recommended by the rehabilitation services department staff. Findings include: I. Resident #26 A. Resident status Resident #26, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included paraplegia (inability to voluntarily move the lower parts of the body), pressure ulcer to the right buttock, neuromuscular dysfunction of the bladder (condition where the nerves controlling bladder function are damaged), anxiety and depression. The 12/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #26 required set up assistance for eating and oral hygiene and was dependent on staff for toileting and showering. The resident required substantial assistance from staff for dressing, rolling from left to right and moving from a sitting to a lying position in bed. B. Resident observation and interview Resident #26 was interviewed on 1/27/25 at 2:42 p.m. Resident #26 was sitting in her wheelchair. There were no side rails on Resident #26's bed. Resident #26 said she was able to move her arms. Resident #26 said she needed bed side rails near the head of her bed in order to be able to move in the bed without significant assistance. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26 said she asked staff for bed side rails on 11/15/24 (the date she was admitted to the facility) and had asked for side rails several times since then. Resident #26 said when someone was paraplegic, the lack of side rails was a restraint, because it did not allow for independence and movement. Resident #26 said if there were side rails on the bed, she would be able to move side to side and would be more independent. C. Record review Resident #26's therapy notes were provided by the regional director of clinical services (RDCS) on 1/29/25 at 10:41 a.m. The therapy notes revealed the following: On 11/16/24, occupational therapy notes documented the resident would benefit from bilateral bed rails for increased independence with bed mobility and repositioning. On 11/30/24, the short term physical therapy goals documented the resident would be able to roll in bed left to right (and back) with bed mobility rails and minimum assistance for pressure relief. D. Staff interviews Registered nurse (RN) #1 was interviewed on 1/28/25 at 3:55 p.m. RN #1 said Resident #26 needed help to reposition in bed. RN #1 said Resident #26 could likely move herself better in bed if there were side rails on the bed. RN #3 was interviewed on 1/29/25 at 9:29 a.m. RN #3 said it could be helpful for Resident #26 to have side rails for her bed. RN #3 said Resident #26 could use her upper arms and the side rails would allow her to turn easier. Certified nurse aide (CNA) #1 was interviewed on 1/30/25 at 12:18 p.m. CNA #1 said Resident #26 asked at the beginning of December 2024 for bed side rails so she could reposition herself in bed. CNA #1 said she told the nurse on duty of the resident's request. CNA #1 said all staff, including the therapy department, knew Resident #26 wanted side rails for her bed. CNA #1 said Resident #26 would be able to reposition herself much better and would gain more independence if she had the side rails on her bed. The physical therapy assistant (PTA) and the occupational therapist (OT) were interviewed together on 1/30/25 at 12:21 p.m. The OT said Resident #26 had requested side rails for her bed. The OT said after the initial OT evaluation, she documented in the resident's electronic medical record (EMR) and sent a text message to the director of rehabilitation to request side rails for Resident #26's bed on 11/16/24 at 11:25 a.m. The PTA said bed rails would allow Resident #26 to reposition herself in bed and would promote her independence. The PTA said she thought Resident #26 would feel more confident in her abilities with the side rails present. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assistant director of rehabilitation (ADOR) was interviewed on 1/30/25 at 12:36 p.m. The ADOR said he did not know whether the bed rails were requested for resident #26. He said the director of rehabilitation (DOR) would know, but was not available. The ADOR said the process to determine if it was safe for a resident to use bed side rails, and then approve and install the bed side rails should take no more than a few days. The director of nursing (DON) was interviewed on 1/30/25 at 1:45 p.m. The DON said she was not aware Resident #26 had requested, nor that therapy had recommended, the side rails. The DON said she would expect the DOR to enter a communication note and to bring a bed side rail request to a daily morning Skilled Review meeting. The DON said the DOR had not entered this request. The DON said Resident #26 could have benefited from bed side rails, as it could assist her with repositioning and independence. The DON said there was a lack of communication which led to the request not being processed. The DON said a request for bed rails could be approved and installed within a few hours. The DON said she was going to confirm that Resident #26 could safely have side rails, and the side rails would be installed on 1/30/25 (during the survey).

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to honor resident choices for one (#30) of one resident reviewed for self-determination out of 53 sample residents. Specifically, the facility failed to promote, facilitate and support a room change for Resident #30, per her preference. Findings include: I. Facility policy and procedure The Resident Self-Determination and Participation policy and procedure, revised August 2022, was provided by the regional director of clinical services (RDCS) on 1/29/25 at 6:35 p.m. It read in pertinent part, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. In order to facilitate resident choices, the administration and staff inform the residents and family members of the residents' right to self-determination and participation in preferred activities, gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record, including information gathered about the resident's preferences in the care planning process. Residents are encouraged to make choices about aspects of their lives in the facility, including rooming with the person of their choice and providing both individuals consent to the choice. II. Resident #30 A. Resident status Resident #30, under age 65, was admitted on [DATE]. According to the January 2024 computerized physician orders (CPO), diagnoses included cerebral palsy (a disorder that affects ability to move and maintain balance and posture caused by brain damage), thoracic scoliosis, pain in the right hip and depression. The 12/16/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff assistance with toileting, bathing, dressing, personal hygiene and transfers. She used a motorized wheelchair for mobility. The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. B. Resident interview (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 was interviewed on 1/27/25 at 2:47 p.m. Resident #30 said her roommate had sundowning (late-day confusion affecting people with dementia) and was loud and her neighbor across the hall yelled out all night due to dementia. Resident #30 said she needed to wear her headphones in order to sleep at night. Resident #30 said it seemed like many of the residents around her had significant cognitive issues and she was not sure her room location and her roommate was the best fit for her since she was younger and had no cognitive issues. Resident #30 said when she first admitted to the facility, she was in the rehabilitation unit and her room was great but later she was moved to her current room. Resident #30 said the last time she talked to the unnamed social worker (SW), the SW had said if she put in a request for a new roommate she may get a worse one. Resident #30 said she knew four other younger residents and thought they may be a better match for her and mainly not to have her sleep disturbed. Resident #30 said the SW had discouraged her from pursuing a formal request for a room/roommate change. Resident #30 said she had had a care conference last month (December 2024) and voiced her wishes but said there had been no follow up from the meeting. C. Record review The respite stay care plan, initiated 9/16/24 and revised 10/8/24, revealed Resident #30 was originally admitted for a 21-day respite stay but later made the decision to stay for long-term care related to 24/7 (twenty-four/seven) care needs. Interventions included to provide an arena such as IDT (interdisciplinary team) care conference for resident, family and/or interested parties to address plans for discharge and participate in the discharge planning process as indicated, social services to document changes to discharge goals per resident preference as indicated and social services to schedule IDT care plan meetings upon admission, quarterly and as needed. -However there were no updates to the care plan interventions following Resident #30's decision to remain in the facility for long-term care. Review of the IDT conference summary, dated 12/5/24, revealed it was a quarterly conference. The activities comment revealed the resident continued to be active and attend groups of interest weekly such as church, bingo, music, entertainment and social. The resident used an electric wheelchair for mobility but needed staff assistance to take her to and from groups of interest and she could make her needs known. The care conference summary revealed that the resident attended the care conference but the social services progress note summary was blank. -Resident #30 said she had told social services of her room/roommate concerns during the IDT case conference, however, the care conference summary note failed to reveal documentation from social services regarding the resident's concerns or any follow up. III. Staff interviews (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 1/29/25 at 1:54 p.m. The SSD reviewed the care conference summary note dated 12/5/24 and said she could not tell from the note what concerns were discussed in the meeting and what were the outcomes because the social services portion of the progress note had not been documented and was blank. The SSD said typically the social services assistant (SSA) would write in the progress note section at the bottom of the form. The SSD said since the SSA did not document anything from the meeting, she did not know what was talked about and discussed. The SSD said she would want social services to write a progress note in the care conference summary because it was important to document what was talked about in the care conference and indicate the facility was discussing ancillary services or any resident concerns. She said social services should additionally document the plan to follow up on residents' concerns, depending on what the concerns were, in a progress note. The SSD said it was important to know what the follow up plan was so she could follow up and make sure the residents were getting the care they needed. The SSD said she had not heard anything about Resident #30 wanting to move to a different room. The SSD said she knew of a good place/room that Resident #30 could move to that might meet her needs better. The SSD said residents were always permitted to request a room change that would better meet their needs. The SSD said the social services department recently made some changes to the department's staff. IV. Facility follow up On 1/29/25 at 2:40 p.m. the SSD said she had spoken with Resident #30 and arranged for a room change for the resident. She said Resident #30 toured the new room and was quite happy with the new room and location. The social services progress noted, dated 1/29/25 at 3:06 p.m. revealed the social services department had spoken with Resident #30 about a room move. The resident verbalized she would like to move to a different room. Available rooms were discussed and the resident toured and chose a new room. The resident was introduced to her new roommate and it was decided that the room move would happen first thing in the morning (1/30/25). Resident #30 verbalized understanding and gave consent for the room change.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46849 Based on observations, record review,and interviews, the facility failed to maintain a system of documenting grievances and demonstrating prompt action for residents for four (#135, #40, #37 and #51) residents out of seven residents reviewed for grievances out of 53 sample residents. Specifically, the facility failed to effectively address, resolve and demonstrate the facility's response to individual grievances for Resident #135, Resident #40, Resident #37 and Resident #51. Findings include: I. Resident group interviews and observations A group interview was conducted on 1/30/25 at 10:30 a.m. with four residents (#135, #40, #37 and #51). The residents were interviewable per the facility and assessment. Resident #135 said when he had a concern , he provided the grievance to a member of the social service staff. He said many times he had not received a follow up on how his grievance was resolved or if it was resolved. Resident #40 said she had filled out two formal grievance forms and provided the forms to staff but received no follow up from social services or administration. She said she was aware of the grievance process and was aware the staff should have spoken with her after she submits a grievance form. Resident #37 said it took approximately two weeks for her to receive any notification of follow up to her grievances and many times she did not receive any follow up at all. She said due to her visual deficits, she required staff to assist her in completing a grievance form. She said this was difficult for her because she must trust the staff were filling the form out correctly and submitting it on her behalf. She said the staff did not read back to her what they had written on her grievance form. Resident #37 said several times she had asked staff to help her fill out a grievance form, was told they were too busy at the time and no one ever returned to complete the form with her. Resident #51 said he submitted a formal grievance to the maintenance assistant regarding a clog in his sink several weeks ago and had not received any follow up. On 1/30/25 at approximately 11:30 a.m. Resident #51's bathroom sink was observed to begin to fill up if the water ran for more than approximately three minutes continuously. II. Record review Facility grievances for the last six months were reviewed. Individual grievances were provided by the social services director (SSD) on 1/30/25. The grievances revealed the following; A grievance dated 11/3/24, was submitted by Resident #37. The grievance pertained to oxygen and medication administration. The date the resolution was discussed with the resident was 12/5/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The grievance was not reviewed with the resident for more than 30 days from the date she had initiated the grievance. A grievance dated 9/28/24, was submitted by Resident #37. The grievance pertained to dietary concerns. The date the resolution was discussed with the resident was 9/30/24. -However, the resident did not sign the resolution, the registered dietitian consultant (RDC) signed in the resident's place. A grievance dated 1/10/25, was submitted by Resident #135. The grievance pertained to resident dignity. The date the staff followed up with the resident after he submitted his grievance was not until 1/20/25. -The grievance was not reviewed with the resident for 10 days after he filed his grievance. No grievances were located by the SSD for a six month look back period for Residents #51 or Resident #40. III. Staff interviews The SSD was interviewed on 1/30/25 at 2:23 p.m. The SSD said she explained the grievance process to new employees during general orientation. She said she expected staff to assist residents who need assistance with completing a grievance form or to locate a member of social services to assist. She said the staff were to provide residents with a grievance form if they could not complete it independently and turn the form in for them if the resident needs assistance. The SSD said during the morning management meeting, the SSD would pass out grievances to the appropriate department to follow up on. She said she requested status updates on outstanding grievances. The SSD said she expected a follow up to be made to the resident within 24 to 48 hours to provide a resolution or to provide an acknowledgment the grievance was being worked on. She said if it took more than a week to resolve, she said the resident was to continue to receive updates. She said once resolved, the department manager would go back and let the resident know the resolution and have the resident sign on the form the resolution was satisfactory. The SSD said she had not received grievances in the last six months for Resident #51 or Resident #40.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure residents were free from abuse for two (#88 and #54) of four residents reviewed for abuse out of 53 sample residents. Specifically, the facility failed to protect Resident #88 and Resident #54 from physical abuse from Resident #144. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised April 2021, was provided by the regional director of clinical services (RDCS) on 1/28/25. It read in pertinent part, Protect residents from abuse and neglect by anyone including but not necessarily limited to: facility staff and other residents. Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, and handling verbally or physically aggressive resident behavior. Implement measures to address factors that may lead to abusive situations, for example, adequately prepare staff for caregiving responsibilities. Identify and investigate all possible incidents of abuse, neglect or mistreatment., Investigate and report any allegations within timeframes required by federal requirements. Protect residents from any further harm during investigations. Establish and implement a quality assurance and performance improvement (QAPI) review and analysis of reports, allegations or findings of abuse, neglect, or mistreatment. II. Incident of resident to resident physical altercation between Resident #144 and Resident #88 on 1/17/25. A. Facility investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation revealed a physical altercation between Resident #144 and Resident #88 occurred in Resident #88's room on 1/17/25. Staff heard verbal commotion down the hall. When staff reached Resident #88's room, Resident #144 was standing next to Resident #88's bed. Staff did not witness any physical action, but Resident #88 stated Resident #144 hit him. Immediately, the nurse removed Resident #144 from the room and placed him on one-to-one supervision and behavior monitoring for the next 72 hours. Staff redirected Resident #144 away from Resident #88's room. Resident #144 was assessed and found to have a skin tear on his right ring finger. The local police department, ombudsman, the residents' physicians and both residents' representatives were notified. Resident #88 was interviewed by staff on 1/17/25 at 3:45 p.m. Resident #88 said Resident #144 came into his room and hit him on his left temple, cheek, side of his chin and several places on his left arm. Resident #88 was assessed after the incident and had no bruising, redness or scratches. The resident denied fear or distress. He was placed on one-to-one observation and psychosocial wellbeing monitoring for the next 72 hours. Resident #144 was interviewed by staff on 1/17/25 at 4:00 p.m. and had no recollection of the incident. Resident #144's psychiatrist initiated medication changes, and the facility initiated referrals to other facilities. Resident #144 was sent to the emergency department for evaluation. Five other residents were interviewed and reported no concerns with Resident #144 or being fearful of the resident. The witness statements were as follows: Certified nurse aide (CNA) #7 said he heard yelling down the hall. When he arrived to Resident #88's room he saw Resident #144 standing over Resident #88 and Resident #88 yelled that Resident #144 had hit him. CNA #7 approached Resident #144 and noticed he had a bleeding cut on his hand. CNA #7 asked Resident #144 what happened and the resident said that Resident #88 was also hitting him. CNA #7 tried to escort Resident #144 out of the room but the resident got agitated and aggressive and started pushing CNA #7 and yelling. CNA #7 said he put gloves on and gently escorted Resident #144 to the day room. He notified nursing staff of the incident and the resident's injured hand. Licensed practical nurse (LPN) #2 said she was told by CNA #7 that Resident #144 and Resident #88 were fighting. She said she saw Resident #144 try to hit CNA #7. She said she approached Resident #144 and tried to redirect him to the recliner. She assessed Resident #144 and cleaned his right hand ring finger, which had a small skin tear. She asked Resident #88 what happened and he said that Resident #144 hit him three times on his face. She said that Resident #88 pointed to the left side of his face, told her that Resident #144 hit him up and down his arm, and then pointed to his left arm. Resident #88 denied pain, and said Resident #144 needed to go. LPN #2 noted no evidence of injury to Resident #88. B. Resident #144 (assailant) 1. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #144, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included cerebral infarct (blocked blood flow to the brain/a stroke), Alzheimer's disease with early onset and unspecified dementia with behavioral and psychotic disturbances. The 12/30/24 minimum data set (MDS) assessment revealed the resident had short term and long term memory problems and had severely impaired cognition and decision making, per staff assessment. He walked independently but was dependent on assistance for bathing and required assistance for all other activities of daily living (ADLs). The assessment indicated the resident had wandered one to three days during the seven-day assessment look-back period. 2. Resident interview An attempt was made to interview Resident #144 on 1/28/25 at 10:43 a.m., however, the resident was not interviewable due to his cognitive impairment. 3. Record review Resident #144's psychosocial care plan, revised 12/12/24, identified the resident was at risk for poor impulse control and decreased well-being related to his adjustment to long-term care. The care plan further identified that the resident had aggressive behaviors and then forgot what happened. It identified his wife's visits as triggers for behaviors. Interventions included assessing clinical issues that may have contributed to the resident's mood pattern, maintaining a calm, slow, understandable approach with the resident and redirecting and reorienting the resident to his environment and routine. The psychosocial care plan further revealed Resident #144 had the potential to be physically and verbally aggressive related to dementia. Interventions included redirecting the resident with snacks and a calm environment when he was yelling, cussing, and balling his fist (initiated 11/28/24), attempting de-escalation techniques, such as providing the resident space and a calm environment (initiated 11/30/24) and having the resident evaluated by his psychiatrist (initiated 11/30/24). -Review of Resident #144's behavior care plan failed to reveal new interventions put into place to prevent further resident to resident altercations after the 1/17/25 incident with Resident #88. Review of Resident #144's pharmacy care plan, revised 12/12/24, revealed the resident required antipsychotic medication related to psychosis. Interventions included administering antipsychotic medications as ordered and gradually reducing the doses as indicated/condition improves, administering non-pharmacological approaches prior to medication administration, providing a quiet and dark environment, assessing the presence of pain/discomfort, keeping the resident as comfortable as possible, providing back rubs as needed, offering warm beverages and observing and reporting signs of hallucinations. A review of Resident #144's January 2025 CPO revealed the following physician's orders: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior monitoring for antidepressant every shift as evidenced by combative with cares, anxiety, agitation and self-isolation, ordered 10/7/24. Monitor behaviors for antipsychotic use as evidenced by hitting walls and inanimate objects. Document every shift in behavior progress note any behaviors observed and any nonpharmacological interventions utilized, ordered 12/10/24. 72-hour monitoring related to aggressive behaviors with staff and agitation, ordered 1/7/25 through 1/10/25. One-to-one monitoring for 72 hours related to a resident to resident incident, ordered 1/17/25. 72-hour behavior monitoring for increase in agitation and/or aggression, ordered 1/17/25 through 1/20/25. A change in condition report, dated 1/17/25 at 4:22 p.m., revealed Resident #144 had altered mental status and behavioral symptoms, including psychosis or agitation. He was noted to have new/worsening memory loss and increased confusion. Behavior changes included physical and verbal aggression. The report indicated the resident was a danger to himself or others. Review of Resident #144's electronic medical record (EMR) revealed the following progress notes: A behavior monitoring progress note, dated 12/29/24, revealed Resident #144 banged and slammed another resident's door and was yelling and cussing. A behavior monitoring progress note, dated 1/7/25, revealed Resident #144 tried to hit a CNA. Another progress note, dated 1/18/25, revealed Resident #144 continued on one-to-one monitoring. The resident was started on Seroquel 12.5 milligrams (mg) every afternoon for severe, unspecified dementia with psychotic disturbance, ordered 1/17/25. A progress note, dated 1/19/25, revealed Resident #144 still had one-to-one monitoring due to incidents of agitation, restlessness and irritability. The resident had episodes when he could not verbalize his needs or make full complete sentences. The resident denied pain and was assisted by staff when walking in the hallway. The resident could not keep his clothing on for long periods, and could not void independently in the bathroom, he voided on the bedroom floor. Staff continued to offer all non-pharmalogical interventions, monitor him, and assist him with all his needs. A progress note, dated 1/20/25, revealed that Resident #144 was asked immediately after the altercation with another resident on 1/17/25 and found to have no recollection of the incident. Interventions included initiation of referrals to two other facilities. The physician initiated medication changes, one-to-one supervision was provided for 72 hours and the resident was sent to the emergency room for evaluation and treatment. The care plan was updated to reflect interventions. Monitoring was ongoing. -However, there were no updated interventions documented on Resident #144's behavior care plan following the incident with Resident #88 on 1/17/25 (see care plan above). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Resident #88 (victim) 1. Resident status Resident #88, age 79, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included Alzheimer's disease. The 11/17/24 MDS assessment documented the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He used a wheelchair or walker for mobility. The assessment indicated the resident had no behaviors. 2. Resident interview Resident #88 was interviewed on 1/28/25 at 9:32 a.m. Resident #88 said he had no issues with other residents and had had no fights. He said he did not want to talk and everything was fine. 3. Record review The comprehensive care plan, revised 12/5/24, identified a psychosocial/behavior focus. The resident exhibited or was at risk for behavioral symptoms, such as grabbing others, being combative, verbally or physically abusive and inappropriately disrobing due to Alzheimer's disease. The resident had a history of sexually inappropriate behaviors and yelling at other residents. Interventions included staff were to attempt de-escalation if these behaviors were seen, intervening before agitation escalated, guiding the resident away from the source of distress, engaging the resident calmly in conversation, walking away calmly and reapproaching the resident later if his response was aggressive, separating, redirecting, distracting and other appropriate methods for ensuring safety of both parties, placing the resident on one-to-one observation until the situation was resolved if de-escalation attempts were unsuccessful, observing and documenting changes in behavior, including frequency of occurrence and potential triggers, including a high stimuli environment and offering a low stimuli environment during meals. A physician's progress note, dated 12/5/24, revealed Resident #88's behaviors were discussed during the interdisciplinary team review (IDT) meeting. Resident #88 had significant and frequent inappropriate sexual behaviors towards staff. He had been physically and verbally inappropriate on a daily basis. He had also been verbally abusive toward at least one other resident and a police report was filed as a result of his behaviors. III. Incident of resident to resident physical altercation between Resident #144 and Resident #54 on 1/27/25 A. Facility investigation The facility's investigation, which was in-progress, for the incident between Resident #144 and Resident #54 on 1/27/25, was received from the director of nursing (DON) on 1/30/25 at 1:00 p.m. The investigation revealed the incident occurred in Resident #54's room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #144 was interviewed by staff immediately after the incident and his responses were unintelligible. Resident #54 was interviewed by staff immediately after the incident and she said she was hit in the face (by Resident #144), but had no injuries she was aware of. She said she did not feel safe with Resident #144 there. Resident #54 was observed lying in bed at the time of her interview, with baseline confusion. On 1/27/25, a witness statement was received from CNA #7. CNA #7 said he was helping another resident when he heard yelling coming out of another room. He saw Resident #144 walking in the hallway. He said by the time he got there, Resident #144 was walking into Resident #54's room. He said he ran down the hall and as soon as he got to Resident #54's door, Resident #144 was yelling and hitting the side of Resident #54's bed. CNA #7 said he told Resident #144 to stop. Resident #144 then hit Resident #54 five times in the rib cage area. CNA #7 said he escorted Resident #144 out of the room and brought him to the day room. He said he notified the nurse and nursing supervisor and then checked on Resident #54. Resident #54 was interviewed again by staff on 1/27/25 at 4:00 p.m. Resident #54 said Resident #144 came into her room and punched her in the face on the right cheek area. She then said he hit her once and left the room. Resident #144 was interviewed again by staff on 1/27/25 at 4:10 p.m. Resident #144 had no recollection of the incident. Five additional residents were interviewed. No other residents said they had been treated roughly by Resident #144 nor were they afraid of him. The investigation revealed the local police department was notified to complete the investigation. Staff and resident interviews revealed Resident #144 entered Resident #54's room and a physical altercation resulted. There were no precipitating signs or behaviors that would have predicted this incident. Resident #144 was calm and cooperative and engaging with staff prior to the incident. -However, Resident #144 had been the assailant in another resident to resident physical altercation 10 days prior, on 1/17/25 (see 1/17/25 incident above). While the investigation was being conducted, Resident #144 was placed on one-to-one monitoring. Resident #54 was offered an immediate room change off the unit, however the resident and her representative declined. The caregiver that regularly visited Resident #54 was noted to be scheduled for a visit that night (1/27/25). Staff continuously rounded to ensure safety on the unit. Social services visits with Resident #54 continued. The local police department, Adult Protective Services (APS), the residents' physicians and the residents' representatives were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #54 was assessed by LPN #2 after the incident and no skin changes were noted. The resident reported pain to her left arm. Her psychosocial well-being was assessed and noted to be different from her baseline. A follow-up assessment revealed Resident #54 had returned to her baseline and did not remember the details of the event. She continued to have no skin alterations and no pain. The resident was engaged in activities and socializing with staff and residents. Resident #54 was interviewed multiple times regarding the incident and continued to say that Resident #144 hit her, but the location changed with each interview. The resident said she had no injuries. B. Resident #144 (assailant) 1. Record review -Review of Resident #144's behavior care plan failed to reveal new interventions put into place to prevent further resident to resident altercations after the 1/27/25 incident with Resident #54. Review of Resident #144's January 2025 CPO revealed the following physician's order following the resident's incident with Resident #54: One-to-one monitoring for 72 hours related to a resident to resident incident, ordered 1/28/25. 72-hour behavior monitoring for increased agitation and aggression related to the incident, ordered 1/28/25 through 1/31/25. C. Resident #54 (victim) 1. Resident status Resident #54, age 87, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included severe unspecified dementia with psychotic disturbance. The 11/27/24 MDS assessment documented the resident had short term and long term memory problems and had moderately impaired cognition and decision making per staff assessment. She used a walker or wheelchair for mobility. The assessment indicated the resident had intermittent inattention, constant disorganized thinking and altered level of consciousness, but no behaviors. 2. Resident interview Resident #54 was interviewed on 1/29/25 at 3:56 p.m. Resident #54 was not fully interviewable due to cognitive impairment, but she said she thought someone hit her yesterday (1/28/25) on her shoulders. She said she thought it was a man and said it did not hurt. She said she felt safe. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the social services care plan, revised 12/12/24, identified Resident #54 was at risk for decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control and adverse effects on function and wellbeing related to diagnosis of post-traumatic stress disorder (PTSD). She had severe, unspecified dementia, with psychotic disturbance. The resident had cognitive loss related to dementia. Interventions included anticipating her needs and meeting them promptly, explaining all care before providing them to reduce resident tension and promote a comfortable experience, approaching her in a calm, reassuring manner, assessing the resident's coping strategies and respecting the resident's wishes, to the extent possible to address the resident's anxiety disorder (initiated 12/12/24). Review of Resident #54's EMR revealed the following progress notes: A change in condition progress note, dated 1/27/25, revealed Resident #54 had been hit by another resident. The resident's physician recommended to continue monitoring Resident #54 and notifying the physician of any further changes. A psychosocial progress note, dated 1/27/25 (after the incident), revealed Resident #54 appeared calm with no visible signs of distress. The resident reported that she was doing better and wanted to get some rest. A physician's progress note, dated 1/28/25, revealed the physician spoke with Resident #54 the day before (1/27/25) and she was confused (her baseline) about the incident on 1/27/25 and said it did not happen. Her representative requested five days of skin checks every shift. The resident appeared tired and was laying in her bed and said she did not wish to get up at the time of the interview. The physician performed a skin check on her torso. There were no abnormalities found. Review of Resident #54's January 2025 CPO revealed a physician's order for five days of skin monitoring. Monitor for redness or bruising on the right side/rib area and to write a progress note if anything appeared abnormal, ordered 1/27/25. IV. Staff interviews CNA #8 was interviewed on 1/29/25 at 4:05 p.m. CNA #8 said she had worked at the facility since October 2024 and had worked with Resident #144 for a while. CNA #8 said when Resident #144 was first admitted to the facility, he was nice and did not have many behaviors, but he declined quickly. She said she thought the resident now got over-stimulated, and then got angry and lashed out. She said he got over-stimulated from noise, people and his surroundings. CNA #8 said toileting Resident #8 had become challenging. She said he forgot where he was at times and needed to be reassured often. CNA #8 said Resident #144 wandered and went in/out of other residents' rooms so staff had to redirect him. She said he probably needed one-to-one supervision permanently now and thought so far it had made a big difference in terms of the altercations he had. She said she thought Resident #144 had had increased supervision for a few weeks following his altercations. She said she was not working during the altercations, but she heard they were resident to resident contact situations and he was going into other residents' rooms. Said a night shift agency CNA had to chase Resident #144 down the hallway. She said she heard that the resident punched Resident #54 in the ribs. She said she heard there was another incident a few weeks prior where he made contact with another male resident (Resident #88). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #9 was interviewed on 1/29/25 at 5:28 p.m. CNA #9 said Resident #144 could not be left alone because his incidents came out of nowhere and could not be anticipated. She said she knew some of his triggers, for example, if he started getting agitated in the shower, she knew to step back and give him a minute. But she said other residents wouldn't necessarily know to do that. The DON was interviewed on 1/30/25 at 11:27 a.m. The DON said she had talked with the psychiatrist regarding Resident #144's decline. She said the psychiatrist said Resident #144's decline was much faster due to his diagnoses of both Alzheimer's disease and Parkinson's disease. The DON said the facility was trying to find a good medication regimen for him. The DON said Resident #144 had problems with impulse control and had poor short-term memory. She said the facility had eliminated some things that triggered the resident's behaviors, such as his wife visiting. She said meeting with his wife virtually had helped some with his behaviors. The DON said she had heard him in the past sitting in his recliner and then he suddenly started to throw dishes. She said she would check on him and ask what was going on and if he was okay. She said Resident #144 never had any recollection of what happened and would say he was fine. The DON said Resident #144 was in the military, so it was possible he had some PTSD which contributed to his outbursts. The DON said Resident #144 had an incident a few weeks ago (1/17/25) with Resident #88. She said there was no contact witnessed between the residents, but Resident #88 said Resident #144 hit him in the face/arm. She said Resident #88 had no evidence of being hit. The DON said Resident #88's memory recall was a little better than Resident #144's and the two residents had never had an issue before. She said the 1/17/25 incident with Resident #88 was Resident #144's first physical altercation incident with another resident. She said Resident #88 was eventually moved to another hallway at his representative's request. The DON said after the 1/17/25 incident with Resident #88, Resident #144 was immediately placed on one-to-one monitoring with documentation being completed every 15 minutes for 72 hours. She said according to the 72-hour documentation, Resident #144 was back to baseline, had no unsafe wandering and no behaviors. She said since a resident to resident physical altercation had only happened once for Resident #144 and the fact that the resident's psychiatrist changed some of his medications soon after, the facility decided to trial the resident off of the one-to-one monitoring. She said the facility had still been tracking his behaviors every shift. She said she thought Resident #144 had started to get more agitated again, but he was doing it all in his room and not coming out of his room. The DON said the facility still had not been able to identify any additional triggers for Resident #144's behaviors. She described his behavior as impulsive and said she had not seen any precipitating behaviors that would have led to the second incident with Resident #54. The DON said after the incident with Resident #54, Resident #144 was probably going to have a full-time one-to-one supervision sitter, unless another medication helped improve the situation. She said the facility had sent referrals for Resident #144 to other facilities due to his behaviors. She said the facility had tried different caregivers for Resident #144 to see if that made any difference for him and it did not.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services and assistance for bathing for two (#48 and #77) of four residents reviewed out of 53 sample residents. Specifically, the facility failed to provide complete grooming with shower/bed bath for Resident #48 and Resident #77 in order to maintain personal hygiene, including shaving of beard, washing of hair and trimming of fingernails. Findings include: I. Facility policy and procedure The Activities of Daily Living, Supporting policy and procedure, revised March 2018, was provided by the regional director of clinical services (RDCS) on 1/29/25 at 6:35 p.m. It read in pertinent part, Residents who are unable to carry out activities of daily living (ADL) independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). II. Resident #48 A. Resident status Resident #48, age 75, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included disorders of bladder, paralytic syndrome following cerebrovascular (CVA) disease affecting left dominant side (stroke), paraplegia (paralysis of the lower half of body) and emphysema. The 11/11/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent on staff assistance with oral hygiene, toileting hygiene, bathing, upper/lower body dressing, personal hygiene (including combing hair and shaving), bed mobility and all transfers. He used a motorized wheelchair for mobility. The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. B. Resident interviews and observations (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 48 was interviewed on 1/28/25 at 9:48 a.m. He had long jagged fingernails on both hands with brown matter visible underneath the nails. Resident #48 said he preferred to have a shower twice a week but the staff did not have time for it. Resident #48's hair was greasy and uncombed. Resident #48 said the staff usually combed his hair and he relied on them to do it. Resident #48 had a full bushy beard, mustache and side burns. Resident #48 said he preferred to have a clean shave since being in the military. Resident #48 said the staff did shave him occasionally, maybe once a week. Resident #48 said he did not know which days he could expect a shower or a shave, as it occurred whenever the staff got around to it. Resident #48 was interviewed a second time on 1/29/25 at 5:12 p.m. Resident #48's hair was long, messy and unkempt. Resident #48 said it had been hectic around his unit. Resident #48 said he was promised a shave but the staff member who promised him the shave never came back to do it. Resident #48 had a full unkempt beard and his fingernails continued to be long and jagged with visible brown matter underneath the nails. C. Record review Review of the bathing care plan, revised 10/4/23, revealed Resident #48 required assistance and was dependent for ADL care related to impaired mobility/cognition due to paralytic syndrome following CVA, chronic pain and muscle weakness. Resident #49's shower preference was for two times per week and he had no caregiver preference. -The care plan failed to include shaving the resident's beard or providing nail care. Review of Resident #48's bathing record from 12/31/24 to 1/28/25 revealed the resident had received six showers over the 30-day period with no resident refusals. The bathing record revealed the resident was dependent on staff for bathing. -However there was no documentation that indicated the resident's fingernails were trimmed or his beard was shaved. III. Resident #77 A. Resident status Resident #77, age 75, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included pressure ulcer of sacral region, heart disease, hemiplegia (paralysis on one side of the body) affecting right dominant side, contracture (permanent shortening and stiffening of muscles and other tissue) of the right hand and major depressive disorder. The 12/3/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She was dependent on assistance with bathing, chair/toilet/bed transfers, and sit-to-stand transfers. She required partial/moderate assistance with bed mobility, oral hygiene, toileting hygiene, upper/lower body dressing and personal hygiene (including combing hair). She required a manual wheelchair for mobility. The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interviews and observations Resident #77 was interviewed on 1/27/25 at 11:58 a.m. Resident #77's hair was dirty and greasy and was not combed. The resident's fingernails were long with brown matter visible under the nails. The resident's right hand was contracted and her fingernails touched into her palm. Resident #77 said she preferred her fingernails short. Resident #77 said she had not been getting out of bed, per her choice, so she had only received bed baths, not showers. Resident #77 was interviewed a second time on 1/29/25 at 5:08 p.m. Resident #77's hair was greasy and unkempt. Resident #77 said she should be getting her hair washed tomorrow (1/30/25), however, she said when the staff did the bed bath, they did not offer to wash her hair unless she insisted they go get the waterless shampoo cap. Resident #77's fingernails were long with brown matter visible under the nails. Resident #77 said she liked her nails short, but the staff had been really busy. Resident #77 said she would ask the staff to trim her nails since they had been too busy to offer. C. Record review Review of the ADL care plan, revised 6/2/24, revealed Resident #77 had an actual self-care deficit and was at risk for further ADL/mobility decline and required assistance related to contractures, history of CVA with hemiparesis, recent hospitalization , weight loss and failure to thrive. -The ADL care plan failed to include bathing or nail care for the resident. Review of Resident #48's bathing record from 12/31/24 to 1/28/25 revealed the resident had received seven bed baths over the 30-day period with one resident refusal. The bathing record revealed the resident was dependent on staff for bathing. -However, there was no documentation that the resident's fingernails were trimmed or her hair was washed. IV. Additional observation On 1/29/25 beginning at 5:46 p.m. the director of nursing (DON) interviewed and observed Resident #48 and Resident #77. The DON confirmed that both residents had long jagged fingernails with brown matter visible under their nails and their hair was greasy and uncombed. The DON said a lack of care with the nails and hair could cause skin infections and skin integrity problems. The DON confirmed with both residents that they wanted to have short, clean fingernails. Resident #48 verified with the DON that he would like his beard shaved and he would like to keep his mustache. The DON acknowledged the residents' grooming concerns and said she would make sure the residents received the necessary services right away. V. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 1/29/25 at 5:17 p.m. LPN #3 said residents should receive a shower two to four times per week, per their preference. LPN #3 said the certified nurse aides (CNA) would tell her if a resident refused grooming, and she would encourage them. LPN #3 said the CNAs charted the residents' showers in the electronic medical record (EMR). LPN #3 said it was important for the residents to receive a shower to keep skin clean, prevent skin break down and promote good hygiene. The DON was interviewed on 1/29/25 at 5:36 p.m. The DON said she recommended a shower at least two times per week. The DON said a shower/bath was important for cleanliness, good hygiene and to minimize risk of infection. The DON said the facility used to have a shower aide but she left, so now the CNAs were doing the showers. The DON said the process for fingernail care was to offer during activities with a manicure, if the resident was not diabetic or the CNAs would offer and ask the residents if they would like their fingernails trimmed during the bathing task. The DON said the bathing task, whether a shower or bed bath, included hair shampoo, nail care, soap and water clean, face washing and teeth/oral care. The DON said beard shaving could be part of the bathing task or some residents had an electric razor, or the CNA would do the shaving upon the residents' request.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure proper treatment and services to maintain vision abilities for one (#137) of three residents reviewed for vision services out of 53 sample residents. Specifically, the facility failed to ensure Resident #137's new eyeglasses were obtained in a timely manner. Findings include: I. Facility policy and procedure The Hearing and Vision Services policy (undated), was provided by the regional director of clinical services (RDCS) on 1/28/25 at 5:10 p.m. It read in pertinent part, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker/social services designee is responsible for assisting residents, and their families, in locating and utilizing any available resources for the provision of the vision and hearing services the resident needs. II. Resident #137 A. Resident status Resident #137, age 83, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, heart disease, hypothyroidism (thyroid gland did not produce enough hormone) and chronic pain. The 12/24/24 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not completed. The resident had a memory problem and his cognitive skills were severely impaired. The resident required substantial assistance from staff for oral hygiene, toileting, dressing, personal hygiene and required supervision for transferring. The MDS assessment documented the resident had adequate vision and did not require corrective lenses. -However, documentation from an eye consult office visit revealed the resident required glasses (see record review below). B. Resident observation and resident representative interview On 1/27/25 at 3:00 p.m. Resident #137 was sitting in the dining room. The resident was not wearing glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #137's representative was interviewed on 1/28/25 at 11:10 a.m. The representative said Resident #137 had worn eyeglasses since he was a child. The representative said Resident #137's eyeglasses had been missing for several months. The representative said Resident #137 saw an optometrist and was provided a prescription for eyeglasses but the eyeglasses were never ordered. The representative said he had asked a facility representative about the eyeglasses on several occasions and was not provided updates regarding the status of Resident #137's eyeglasses. C. Record review The 8/5/24 eye exam note, entitled Summary Ocular Progress Note, was provided by the RDCS on 1/30/25 at 1:05 p.m. The eye exam note included instructions to deliver Resident #137's prescribed eyeglasses two weeks from the receipt of payment. A nursing progress note, dated 10/1/24 at 7:37 p.m., revealed Resident #137's representative was notified that the resident's glasses were on order and management had reached out to the eye doctor for an estimated time for when they would be delivered. -Review of Resident #137's electronic medical record (EMR) on 1/30/25 did not reveal documentation to indicate the resident had received his new eyeglasses. D. Staff interviews The social services director (SSD) was interviewed on 1/30/25 at 12:09 p.m. The SSD said Resident #137 should have received his eyeglasses. The SSD said the facility changed vision providers and said this could have contributed to the delay. The SSD was interviewed a second time on 1/30/25 at 12:49 p.m. The SSD said she was responsible for ensuring Resident #137 received his eyeglasses in a timely manner. The SSD said she had been trying to catch up with residents' ancillary needs since she started in her position at the facility in April 2024. The director of nursing (DON) and the RDCS were interviewed together on 1/30/25 at 1:52 p.m. The DON said Resident #137's eyeglasses were ordered on 1/30/25 (during the survey). The RDCS said there were gaps in the process to order the eyeglasses for Resident #137. The RDCS said she would expect the process to obtain new eyeglass prescriptions to not take longer than six to eight weeks.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#4) of three residents out of 53 sample residents. Specifically, the facility failed to ensure staff were aware of and following the care planned interventions for Resident #4 in order to prevent further falls. Findings include: I. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included unspecified dementia, osteoporosis, muscle weakness, unspecified lack of coordination and left artificial hip. The 11/25/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments. The resident could not complete the cognitive assessment therefore a staff assessment was completed. The staff assessment revealed the resident had short and long term memory deficits, impaired decision making, and was only oriented to herself. The MDS assessment documented the resident used a wheelchair for mobility and required moderate assistance from staff for bed mobility and transfers. The MDS assessment indicated the resident required supervision and hands-on assistance with ambulation. The MDS assessment indicated the resident had not had any falls since the prior assessment. B. Resident observations On 1/27/25 at 11:30 a.m. Resident #4 was ambulating in the hallway with sock-like slippers on. She was pushing another resident in their wheelchair. She was observed with a raised, large hematoma (a pool of blood under the skin or in the body caused by a broken blood vessel) on the left side of her forehead with bruising to the left forehead area and under her left eye. Registered nurse (RN) # 4 walked past Resident #4, but did not discourage the resident from ambulating on her own or pushing the other residents' wheelchair. At 11:34 a.m., four minutes after initially walking past Resident #4, RN #4 returned and asked the resident not to push other residents' wheelchairs. RN #4 took Resident #4's hand and guided the resident away from the other resident's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 11:20 a.m. Resident #4 was ambulating independently with an unsteady gait and sock-like slippers on her feet. Several staff members were present in the area but did not provide ambulation assistance to the resident. On 1/29/25 at 11:51 a.m. Resident #4 was ambulating independently with an unsteady gait and sock-like slippers on her feet. Several staff members were present but did not provide ambulation assistance to the resident. On 1/29/25 at 4:46 p.m. Resident #4 was ambulating independently with sock-like slippers on her feet and holding another resident's hand while pulling the other resident in their wheelchair. The memory care director (MCD) came up to Resident #4 and asked to hold her hand so she would stop pulling the other resident in their wheelchair. C. Record review Resident #4's fall care plan, revised 10/17/24, revealed the resident was at risk for falls due to dementia, gait/balance problems, history of falls and history of femur fracture and rib fracture. Interventions included anticipating and meeting the resident's needs (initiated 9/21/23), encouraging and assisting the resident to use a wheelchair for ambulation (initiated 10/30/23), ensuring the resident was wearing non-skid socks or non-skid footwear (initiated 5/13/24), educating the staff to keep the resident in line of sight (initiated 1/14/25) and ordering a therapy evaluation for the use of a four-wheel walker (FWW) (initiated 1/20/25). A post-fall review assessment, dated 1/15/25, revealed the resident had a fall on 1/14/25. A post-fall review assessment, dated 1/20/25, revealed the resident had a fall on 1/20/25. A review of Resident #4's progress notes from 1/14/25 through 1/30/25 revealed the following: A 1/14/25 change of condition assessment progress note revealed Resident #4 had a fall. The physician ordered a new prescription for as needed pain medication. A 1/14/25 change of condition fall progress note dated revealed a housekeeper had found Resident #4 lying on the floor at the end of a hallway in her unit. When the nurse arrived to assess the resident, the resident was standing up and screaming out. She was observed to be holding the hand of another resident who had helped her stand up. No injuries were observed by the nurse. A 1/15/25 interdisciplinary team (IDT) fall note dated revealed the new interventions put into place for the 1/14/25 fall included educating the staff to keep Resident #4 within sight in common areas and to update the care plan. A 72-hour charting note, dated 1/17/25, revealed Resident #4 was observed walking the unit unassisted and constantly attempting to engage with the nursing staff, however, the resident was unable to articulate herself. -The note did not indicate if staff attempted to assist the resident with ambulation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 1/20/25 change of condition assessment progress note revealed Resident #4 had suffered a fall after ambulating in the hallway and letting go of a hand rail which caused her to fall. The resident was observed with discoloration to her forehead and the physician ordered the resident be sent out to the hospital for a contusion to her head. A 1/20/25 nursing note revealed the resident had returned from the hospital with a hematoma to her scalp, was grimacing and verbally complaining of pain and pointing at her right hip. A 1/21/25 IDT skin note revealed Resident #4 had a contusion to the left forehead with edema and discoloration. A 1/21/25 resident safety note revealed occupational therapy issued a FWW for Resident #4 to use. The staff were provided education to watch the resident while the new device was being initiated. The resident demonstrated good results for use. A 72-hour charting note, dated 1/21/25, revealed physical therapy worked with the resident on her use of the FWW. This was effective until the resident saw another resident she liked to hold hands with and then she let go of the walker. Redirection with the resident was effective. -However, staff were not observed during the survey to be assisting Resident #4 with ambulation, redirecting the resident when she was ambulating unassisted or encouraging the resident to utilize the FWW (see observations above). II. Staff interviews RN #4 was interviewed on 1/27/25 at 11:30 a.m. RN #4 said Resident #4 used to be a nurse and thought she was working. She said the resident liked to assist and push other residents in their wheelchairs. RN #4 said the resident's fall interventions were to keep her within their line of sight when she was out of her room. RN #4 said she thought the resident's walker was in her room but the resident did not use it. Certified nurse aide (CNA) #3 was interviewed on 1/29/25 at 11:58 a.m. CNA #3 said Resident #4 could ambulate independently without a walker or wheelchair. -However, according to the resident's 11/25/24 MDS assessment, care plan and progress notes, Resident #4 required hands-on assistance with ambulation or the use of a wheelchair or FWW (see resident status and record review above). The director of nursing (DON) was interviewed on 1/30/25 at 12:54 p.m. The DON said when a resident had a fall, the nurses were to complete an assessment of the resident's condition. The DON said an immediate new fall intervention was determined and the managers attempted to identify the root cause of the fall. The DON said once a new intervention was put into place, a manager was assigned to monitor the intervention's implementation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the new interventions for Resident #4's fall on 1/14/25 were to educate the staff regarding keeping her in their line of sight and monitoring her for 72 hours. The DON said the new interventions put into place post fall on 1/20/25 were to have the therapy department evaluate the resident for a FWW. The DON said she did not know why the staff were not encouraging the resident to use her walker for ambulation. The DON said she was unaware Resident #4 had been wearing slipper-like socks instead of non-skid socks or footwear.

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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. 43950 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 three of three certified nurse aides (CNA). Specifically, the facility failed to complete annual performance reviews and/or provide regular in-service education based on the outcome of the reviews for CNA #4, CNA #5 and CNA #6. Findings include: I. Facility policy and procedure The Performance Evaluations policy and procedure, revised September 2020, was provided by the regional director of clinical services (RDCS) on 1/30/25 at 3:33 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 completed on each employee at the conclusion of his/her 90-day probationary period and at least annually thereafter. II. Record review Annual performance reviews were requested on 1/29/25 at 4:05 p.m. The facility was unable to provide annual performance evaluations for 2024 for CNA #4 (hired on 12/9/23), CNA #5 (hired on 12/26/23) and CNA #6 (hired on 10/7/2020). -CNA #4, CNA #5 and CNA #6 did not have an annual performance review completed and did not have an in-service education plan based on the outcome of the review. III. Staff interviews The RDCS was interviewed on 1/30/25 at 3:25 p.m. The RDCS said the facility did not have the performance reviews for CNA #4, CNA #5 and CNA #6. The RDCS said she understood the importance of performing annual performance evaluations so that proper in-services could be conducted following the reviews. The director of nursing (DON) was interviewed on 1/30/25 at 4:05 p.m. The DON said she was new to her role of DON as of 11/15/24. The DON said performance reviews needed to be completed for CNAs annually, but she said she did not know where the former DON kept the records for the staff. The DON said she would start the performance reviews of the CNAs as soon as possible and then provide them with the in-service training they may need.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 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 possible development and transmission of infectious disease on three of nine units. Specifically, the facility failed to: -Ensure housekeeping staff wore gloves and performed appropriate hand hygiene while cleaning residents' rooms; -Ensure housekeeping staff wore masks appropriately while the facility was in a flu outbreak; and, -Ensure staff sanitized dining tables and the floor prior to the next meal. Findings include: I. Housekeeping failures A. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy, revised August 2013, was provided by the regional director of clinical services (RDCS) on 1/30/25 at 2:39 p.m. It read in pertinent part, Use heavy-duty gloves and other personal protective equipment (PPE), as indicated, for housekeeping tasks. Gloves, protective eyewear and masks may be indicated to reduce exposure levels to disinfectant chemicals as well as to protect employees from exposure to blood and OPIM (other potentially infectious materials) while cleaning or disinfecting. Perform hand hygiene after removing gloves. B. Observations On 1/29/25 at 8:42 a.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER]. HK #1 reached her ungloved hand into a clean bucket, retrieved a mophead and applied the mophead to her mop. After using the mop, HK #1 removed the dirty mophead and disposed of it with ungloved hands. -HK #1 did not perform hand hygiene after removing the dirty mophead with her ungloved hands. HK #1 proceeded to empty the trash can with her ungloved hands. -HK #1 did not perform hand hygiene after emptying the trash can. HK #1 licked her fingers and opened a clean trash bag with her ungloved hands, which she had not sanitized after removing the dirty mophead with her ungloved hands or emptying the trash can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HK #1 did not perform hand hygiene after licking her fingers. On 1/29/25 at 8:50 a.m., HK #1 was observed cleaning room [ROOM NUMBER]. HK #1 reached her ungloved hand into a clean bucket, retrieved a mophead and applied the mophead to her mop. After using the mop, HK #1 removed the dirty mophead and disposed of it with ungloved hands. -HK #1 did not perform hand hygiene after removing the dirty mophead. HK #1 proceeded to reach her ungloved hand into the bucket of clean mopheads again to retrieve another mophead. C. Staff interviews HK#1 was interviewed on 1/29/25 at 9:00 a.m. HK #1 said she should have worn gloves to obtain and dispose of the mophead. She said she should have used hand sanitizer after touching the dirty mophead. HK #1 said some residents' trash cans looked clean so she did not always wear gloves. HK #1 said she should have worn gloves to empty the trash. -During the interview, HK#1 was observed wearing a mask under her nose, despite the fact that the facility was in a flu outbreak during the survey. The housekeeping supervisor (HKS) was interviewed on 1/29/25 at 9:30 a.m. The HKS said HK#1 should have worn gloves and changed gloves between tasks when cleaning the residents' rooms, including when removing trash from the rooms and when she discarded the dirty mopheads. The HKS said HK #1 should have used hand sanitizer before applying gloves and between changing gloves. The infection preventionist (IP) was interviewed on 1/29/25 at 1:55 p.m. The IP said HK #1 should have worn gloves at all times while cleaning the residents' rooms and changed gloves and performed hand hygiene between dirty and clean tasks. The IP said HK#1 should have washed her hands with soap and water after licking her fingers. The IP said HK #1 should have covered her nose when wearing her mask. II. Failure to sanitize dining tables and the floor between meals A. Observations On 1/27/25 at 11:32 a.m. the dining room in the 100 hallway was observed. There were five tables in the dining room. There were bread/dessert crumbs on three dining tables and beverage cup liquid markings and other stains present on four of the dining tables. At 12:09 p.m. stains and crumbs were still present on the 100 hallway dining tables and there were four residents sitting at the tables waiting for lunch and drinking beverages. At 12:43 p.m. meal service began and the dining tables in the 100 hallway dining room had not been cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 9:15 a.m. the dining room on the 100 hallway was observed again. There were crumbs on the floor and dirty marks/dried beverage spots on two of the four dining tables after the breakfast meal. At 12:26 p.m. there were still crumbs on the floor and the same spots on the tables in the 100 hallway dining room. Three residents were sitting at the dining tables awaiting lunch. On 1/29/25 at 11:30 a.m. the dining room on the 100 hallway was observed. There were bread/dessert crumbs on three of the dining tables, crusty substances on three of the dining tables' edges and beverage spots on one dining table. The dining table closest to the entrance of the dining room still had liquid spots in the same locations observed on 1/27/25 and 1/28/25 (see above). Crumbs were present on a chair and on the floor under the dining tables. A plastic cup lid was on the floor. At 11:55 a.m. a housekeeper was cleaning the 100 hallway and walked with the housekeeping cart past the dining room. The housekeeper did not clean the dining room. At 12:41 p.m. the 100 hallway dining room was observed in the same condition. The dining tables, chair and floor had not been cleaned. At 12:56 p.m. two residents were observed in the 100 hallway dining room. They sat at a dining table and began drinking coffee. The dining tables had not been wiped/sanitized and the room was in the same condition. At 12:57 p.m. a resident sat at another dining table that had not been wiped/sanitized. At 12:59 p.m. meal service began in the 100 dining room and the dining tables had not been cleaned. At 3:49 p.m. the dining tables were in the same condition with crumbs and dried beverage stains. In addition, there were two plastic beverage cup lids on the floor and additional crumbs on the floor. At 5:15 p.m. two of the beverage stains on a dining table were able to be partially removed when wiped with a wet paper towel. At 5:31 p.m. two residents were observed eating at a dining table which had not been cleaned. B. Resident interview Resident #40 was interviewed on 1/30/25 at 10:30 am. Resident #40 said many times the dining room was not cleaned after meals. Resident #40 said she had gone into the dining room for Bingo at 2:30 p.m. on several occasions and there was still food on the tables or trays with food stacked in racks in the dining room. C. Staff interview The dietary manager (DM) was interviewed on 1/29/25 at 5:39 p.m. The DM said the dietary aides were responsible for cleaning the dining room tables and serving areas in the 100 hallway dining room. He said the dietary aides were supposed to clean the dining rooms after every meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DM said there were cleaning logs for the other dining rooms, however, he said he did not think there was a cleaning log for the 100 hallway dining room. The DM said there should be a cleaning log for the 100 hallway dining room. The DM said the staff should ensure the tables were clear of food debris and stains and remove trash so residents would feel comfortable sitting at the tables. The DM said the cleaning of the 100 hallway floor was the responsibility of the dietary aides and housekeeping was also responsible for cleaning the floors. The DM said he was going to communicate with the nursing staff to assist with cleaning the 100 hallway dining room. The DM said he would also communicate with the housekeeping supervisor to establish a 100 hallway dining room cleaning schedule for the housekeeping department.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46849 Based on observations, record review and interviews, the facility failed to provide a safe, sanitary, functional and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure necessary kitchen equipment was maintained in a safe, sanitary and working condition. Findings include: I. Observations On 1/27/25 at 9:30 a.m. the initial kitchen tour was conducted and the following was observed: -An approximate twelve-inch by twenty-four inch puddle of water was observed coming from underneath the kitchen employee's hand washing sink. -Under the three compartment dishwashing sink, a large silver mixing bowl was observed directly underneath the water pipes. The mixing bowl was collecting the drops of water from a leak in one of the pipes. -Two broken floor tiles by the sink were detached from the floor and floating on top of an accumulation of water. On 1/28/25 at 11:18 a.m. observations of the kitchen revealed there were no changes to the condition of the leak coming from underneath the kitchen employee's hand washing sink, the leak coming from the pipe underneath the three compartment dishwashing sink or the broken floor tiles that were floating on top of an accumulation of water. On 1/28/25 at 1:52 p.m. observations of the kitchen revealed there were no changes to the condition of the leak coming from underneath the kitchen employee's hand washing sink, the leak coming from the pipe underneath the three compartment dishwashing sink or the broken floor tiles that were floating on top of an accumulation of water. II. Staff interviews The dietary manager (DM) was interviewed on 1/28/25 at 1:26 p.m. The DM said the facility used an electronic work order system to enter work orders to the maintenance department for repairs. The DM said the kitchen staff were to notify him or one of his night supervisors to put repair orders into the system. The DM said he had been aware of the leaking pipe underneath the three compartment dishwashing sink for at least a week. He said he told someone in maintenance about it but could not recall who he had told or when he had done this. -The DM entered a work order to repair the leak, after it was observed during the survey. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DM said he was unaware of the leak and puddle of water underneath the employee's hand washing sink. He did acknowledge it was the main employee hand washing sink when the staff first came into the kitchen. He said his expectation was for the staff to go to the sink and wash their hands before performing any tasks in the kitchen. He said the outcome for leaks that were not addressed was water damage, resulting in the potential for mold in the kitchen. An environmental tour of the kitchen was conducted with the maintenance director (MTD) and the nursing home administrator (NHA) on 1/28/25 at 1:52 p.m. The MTD said he had ordered the part to repair the pipe leak underneath the three compartment dishwashing sink on 1/27/25 (during the survey). He said prior to the survey, he was unaware of the leak and had not received a work order from the DM. The MTD said the leak coming from underneath the employee's hand washing sink was due to a disconnected drain pump from the ice machine next to the sink. He said the disconnected drain pump was causing the water leak to come from underneath the ice machine and travel underneath the hand washing sink. It was observed the material at the base of the hand washing sink was soft and warped consistent with water damage. The MTD said he would reconnect the drain pump and repair the warped base of the sink. The NHA said a work order should have been submitted in the electronic work order system in order for the MTD or the maintenance assistant (MTA) to repair the leaks. The MTD said during new hire employee orientation, he provided education to staff on the electronic work order system and how to enter work orders. -During the interview, the work order system training for the DM was requested from the MTD and the NHA, along with the agenda for the new hire orientation section on work orders. III. Facility follow up On 1/28/25 at 2:20 p.m. the regional director of clinical services (RDCS) provided an email with an attached document titled Maintenance Education. The document included instructions on how to enter a work order, the contact numbers for the MTD and the MTA, the maintenance problems to direct to the MTD and MTA and the fire alarm code. -However, the Maintenance Education document was not dated with the date the education was provided and did not include any staff signatures to identify who received the education.