STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065418	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Ridge	16006 W US Hwy 24 Woodland Park, CO 80863

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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 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** 48112 Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for two (#68 and #70) of five residents reviewed for falls out of 33 sample residents. Specifically, for Resident #68 and #70, the facility failed to: -Identify the root cause of falls and implement timely and effective interventions to prevent further falls; and, -Update and revise the residents' care plans with new interventions after each fall. Findings include: I. Facility policy. The Fall Clinical Protocol policy, revised March 208, was provided by the director of nursing (DON) on 5/16/24 at 1:44 p.m. It read in pertinent part, Staff will begin to try to identify possible causes within 24 hours of the fall. The staff will continue to collect and evaluate information until either the cause of the fall is identified or it is determined that the cause cannot be found or is not correctable. If underlying causes cannot be readily identified, staff will try various relevant interventions based on assessment until fall reduces or stops or until a reason is identified for its continuation. II. Resident #68 A. Resident status Resident #68, age [AGE] years old, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia with agitation, abdominal pain, vascular (blood vessels) disorder of the intestine and cystic disease (condition that causes fluid filled sacs) of the liver. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/13/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. The resident required partial assistance with oral hygiene and dress. He required substantial assistance with showering and personal hygiene. He required supervision with toileting. B. Record review Resident #68's fall care plan, revised 1/4/24, revealed the resident was at risk for falls related to confusion and poor safety awareness. Interventions included ensuring the resident wore non-skid shoes when ambulating and anticipating the resident's needs. The vision care plan, revised 8/16/23, revealed the resident had impaired visual functions in both eyes. Interventions included reminding the resident to wear glasses and ensuring glasses were clean and free from scratches. A 4/13/24 fall nurse note revealed Resident #68 had an injury to the left side of his eye, brow and bridge of his nose. -A 4/14/24 nurse note revealed there was bruising noted over the bridge of his nose, left eye upper and lower eyelids and lateral aspect of the left eye. There was black and blue bruising of his bilateral hands. -An incident report was requested for the 4/13/24 fall but not provided. A 4/25/24 interdisciplinary team (IDT) progress note revealed a fall meeting was held. The fall from 4/13/24 was reviewed. The new intervention was for physical therapy to do an evaluation. -The intervention was not implemented until 12 days after the resident's 4/13/24 fall. -The interdisciplinary team (IDT) did not identify the root cause of the fall. -The new intervention for a physical therapy evaluation was not added to the Resident #68's fall care plan. A 5/16/24 fall incident report was reviewed. The resident was found on the floor in the secure unit dining room. The report documented the resident tried to maneuver around another resident's wheelchair and his foot was caught in the other resident's wheelchair's back wheel. He tried to hold onto the wheelchair's handles but lost his balance and fell on his right side. -The incident report did not identify any new fall interventions that were implemented at the time of the fall. A 5/17/24 nurse note revealed the resident continued to walk around the unit. He looked down at the floor while walking instead of looking ahead. A 5/19/24 nurse note revealed the resident walked around the unit with his head down at the floor or bent over to pick up items from the floor. Staff monitored the resident to give safety prompts as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no IDT note documented to indicate the fall had been reviewed by the IDT and new interventions were implemented. -The fall care plan did not identify new interventions after the fall. -The IDT did not identify the root cause of the fall. The 5/22/24 fall risk assessment revealed that the resident fell before, did not use an assistive device, such as a wheelchair or walker to ambulate, had a weak gait and overestimated or forgot his limits. He scored a 65 which indicated he was a high risk to fall. D. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 5/23/24 at 11:32 a.m. CNA #6 said she knew a resident was at a high fall risk if the resident used oxygen, if they were woozy or if the resident tried to stand without assistance when the resident required assistance. She said she kept an eye on residents to prevent a fall. She said she was familiar with Resident #68. She said he was a high fall risk. She said she kept an eye on the resident, encouraged the resident to sit down and kept food and water close to him to prevent him from falling. Registered nurse (RN) #2 was interviewed on 5/23/24 at 11:40 a.m. RN #2 said she knew a resident was at a high fall risk based on their gait, diagnoses and observation of the resident. She said she made sure the area was clear of spills to prevent a fall. She said she was familiar with Resident #68. She said he was a high fall risk. She said she asked him to sit and walked with him to prevent him from falling. The DON was interviewed on 5/23/24 at 10:13 a.m. The DON said staff knew a resident was a high fall risk based on a fall star placed on the door of residents who were a high fall risk. She said a nurse knew a resident was a fall risk based on the fall assessment. She said the nurses communicated to the staff verbally when a resident was a fall risk. She said if a resident fell , a RN completed an assessment and started a fall protocol that included neurological checks. The DON said the nurse should look at what happened to cause the fall and add a fall intervention to prevent further falls. She said the IDT met weekly and added further interventions if appropriate. She said she was familiar with Resident #68. She said he was a high fall risk. The DON said there was not a root cause analysis done for Resident #68's falls on 4/13/24 and 5/16/24. She said she was not aware Resident #68's eyesight was decreasing and his head was down frequently. She said if she knew she would include therapy and maintenance to develop interventions to prevent accidents and falls. The DON said interventions were not reviewed and a new intervention was not added for Resident #68's fall on 5/16/24. She said the nurse who completed the nurse assessment should identify the initial root cause of the fall and an intervention. V. Facility follow up (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/24 at 7:23 a.m. the minimum data set coordinator (MDSC) sent a performance improvement plan which indicated the facility had created an action plan to review falls and interventions in a timely manner and to decrease the number of falls. It revealed the steps included reviewing falls, reviewing interventions, staff considerations, staff education and staff awareness of high fall risk residents. -The follow-up plan did not include dates when the action steps were completed. 31229 III. Resident #70 A. Resident status Resident #70, age 81, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included malignant melanoma of skin, malignant neoplasm of prostate, malignant neoplasm of brain, nontraumatic intracerebral hemorrhage, and history of falling. The 2/29/24 MDS assessment revealed the resident's cognition was severely impaired with a BIMS score of six out of 15. He had no behaviors. He required partial moderate assistance with toileting, dressing, personal hygiene and transfers. B. Resident representative interview Resident's #70's representative was interviewed on 5/20/24 at 3:45 p.m. The representative said the resident was falling frequently at home and in the facility. She said the resident still thought he was strong and tried to do things he used to, such as getting up and walking. She said he was not able to use the call light to call for assistance with transfers. C. Record review The fall care plan, initiated 3/7/24, revealed the resident had a history of falls due to poor balance, poor communication/comprehension and unsteady gait. Interventions included placing a fall mat by the resident's bed while he was in bed (initiated 4/1/24), placing a wedge cushion in the resident's wheelchair (initiated 4/8/24), placing a silent bed sensor (bed alarm) on the resident's bed (initiated 4/23/24), staff to provide frequent checks on the resident (initiated 4/23/23) and providing a lipped mattress on the bed (initiated 5/16/24). -Despite the resident's history of frequent falls (see resident's diagnoses and resident representative interview above), the facility failed to initiate a fall care plan with interventions to prevent falls until 3/7/24, after Resident #70 sustained a fall on 3/6/24 (see below). -The care plan failed to specify how often frequent checks should be conducted for Resident #70. On 2/17/24, a nursing note revealed Resident #70 was admitted to the facility under hospice care. The note documented the resident was admitted to the facility following falls at home. The resident required extensive assistance of one staff member for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Fall on 3/6/24 On 3/6/24 at 5:45 a.m. a nurse documented Resident #70 sustained an unwitnessed fall. The resident was noted to be on the floor at the side of his bed, face down. The resident had been displaying increased restlessness and/or confusion during the night. The resident's call light had been in reach, but the resident did not always use it to call for assistance from staff. -The progress note failed to document a new intervention to prevent further falls. -There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall. 2. Fall on 3/26/24 On 3/26/24, a nurse documented Resident #70 was sitting in one of the regular chairs, watching TV (television) in the lounge area. The resident's wheelchair was locked/parked close to the chair. The nurse heard a noise and found the resident lying on his back on the floor in front of the chair he had been sitting in and the resident's wheelchair had been unlocked. The resident was placed in bed with the bed in low position and the call light in reach. The door to the resident's room was left open so he could be monitored by the staff. The nurse encouraged the resident to call for assistance when needing to transfer. The resident continued to display his usual episodes of forgetfulness/confusion and made some comments to the nurse that he could stand on his own. -The progress note failed to document a new intervention to prevent further falls. -There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall. -The resident's fall care plan was not updated until 4/1/24 (six days after the fall) when a floor mat was added as an intervention (see care plan above). 3. Fall on 4/4/24 On 4/4/24 at 10:30 p.m. a nurse documented Resident #70 was found sitting on the floor in front of his wheelchair in the hallway. Two staff members used a gait belt to stand the resident and get him in his wheelchair. The resident had been watching TV late in the TV room. -The progress note failed to document a new intervention to prevent further falls. -There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall. -The resident's fall care plan was not updated until 4/8/24 (four days after the fall) when a wedge cushion was added to the resident's wheelchair as an intervention (see care plan above). 4. Fall on 4/14/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/24 at1:14 a.m. a nurse documented Resident #70 was found sitting on the floor with his feet towards the wall, holding on to the bed halo (bed rail). The resident was unable to state what occurred but mentioned his wife and trying to meet with someone. The resident was reoriented to time. He required a two) person assistance back to bed. -The progress note failed to document a new intervention to prevent further falls. -There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall. -The resident's fall care plan was not updated until 4/23/24 (when the resident sustained another fall which was nine days after the 4/14/24 fall) when a bed alarm and frequent checks on the resident were added as interventions (see care plan above). 5. Fall on 4/23/24 On 4/23/24 at 7:11 a.m. a nurse documentedResident #70 had been in his wheelchair in the lounge area watching TV. The nurse was searching for him and found him on the floor beside his bed in his room. The resident had closed the door to his room. The floor mat was beside the bed and the resident had landed on the floor mat. The resident's call light was in reach, but the resident did not use it to call for staff assistance. -The progress note failed to document a new intervention to prevent further falls. -There was no IDT follow up note for the fall which indicated the facility identified a root cause for the fall. 6. Fall on 5/16/24 On 5/16/24 at 6:30 a.m. a nurse documented Resident #70 attempted to transfer himself out of bed and was found by CNA lying on the fall mat beside his bed. The 5/16/24 IDT fall review note documented the hospice services provider was to provide a lipped mattress. No further interventions were documented. D. Staff interviews CNA #7 was interviewed on 5/22/24 at 10:45 a.m. CNA #7 said Resident #70 was falling frequently during evening or nighttime looking for his wife or trying to get out of bed. She said the resident's room was across the nurses' desk and the staff was keeping an eye on him through the open door. RN #3 was interviewed on 5/22/24 at 10:55 a.m. RN #3 said most of Resident #70's falls happened at night. She said the resident was not able to understand or remember to use his call light. She said he did not have any of his falls on her shifts (during the day). CNA #8 was interviewed on 5/23/24 at 1:18 p.m. CNA #8 said she checked on Resident #70 frequently and took him to the toilet. She said the resident did not fall on her shifts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #4 was interviewed on 5/23/24 at 1:23 p.m. RN #4 said the resident had been falling usually in the late afternoon and at night. She said he had a short attention span. She said the resident would not participate in activities for longer than a couple of minutes before he started looking for his wife. RN #4 said when he was in the living room watching TV he would try to stand up and look for his wife. She said he did the same thing when he was in bed. She said as soon as he opened his eyes he would try to stand up and ask the staff about his wife. She said the best approach to prevent falls for the resident would be to have someone with the resident at all times. RN #4 said his wife lived very close to the facility and visited most of the weekdays in the afternoon. The DON was interviewed on 5/23/24 at 3:00 p.m. The DON said falls were reviewed in the facility during morning stand-up meetings and approaches to prevent falls were discussed. She said the IDT was meeting to review falls weekly and there was a new fall intervention added after each fall for Resident #70. -However, Resident #70's progress notes and care plan did not reflect that a new intervention was added timely after each of the resident's falls (see record review above).

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure one (#68) of four residents reviewed for nutrition received the care and services necessary to meet their nutritional needs and maintain their highest physical well-being level out of 33 sample residents. Resident #68 was admitted to the facility for long term care on 8/1/23 with diagnoses of dementia with agitation, abdominal pain, vascular disorder of the intestine (blocked blood vessels to the intestines) and cystic disease of the liver (a disease that causes growths in the liver). Upon admission, Resident #68 weighed 212.4 pounds (lbs). The resident was hospitalized from 10/13/23 to 10/19/23 for a large bowel ischemic (a condition that caused pain and difficulty for intestines to work properly) and necrosis of the colon (part of the colon dies). Resident #68's weight was stable between September 2023 to November 2023 after the hospitalization . On 12/4/23 Resident #68 sustained a 7% (13.8 lbs) weight loss from 11/7/23 to 12/24/24, which was considered severe. On 12/5/23 the registered dietitian (RD) recommended to provide the resident large portions at meals to provide additional calories and nutrition to combat the severe weight loss. Observations on 5/21/24 and 5/22/24 revealed the resident did not receive large portions and was not offered additional food when he consumed 100% of his meal. On 2/5/24 Resident #68 sustained an additional 6.9% (12.6 lbs) weight loss from 1/3/24 to 2/5/24, which was considered severe. The facility did not implement a person-centered nutritional intervention related to the resident's severe weight loss. Due to the facility's failures to provide timely and effective nutritional interventions and ensure staff followed implemented nutritional interventions, Resident #68 sustained a severe weight loss. Findings include: I. Facility policy and procedure The Nutritional Assessment policy, revised October 2017, was provided by the director of nursing (DON) on 5/23/24 at 11:47 a.m. It revealed in pertinent part, The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Individualized care plans shall address, to the extent possible, the identified causes of impaired nutrition, the resident's personal preferences, goals and benchmarks for improvement and timeframes and parameters for monitoring and reassessment II. Resident #68 A. Resident status Resident #68, age [AGE] years old, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia with agitation, abdominal pain, vascular disorder of the intestine and cystic disease of the liver. The 2/13/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. The resident required partial assistance with oral hygiene and dressing. He required substantial assistance with showering and personal hygiene. He required supervision with toileting, The assessment documented the resident was 75 inches (six feet, three inches) tall and weighed 183 lbs. It indicated the resident had no weight loss or weight gain in the last six months. -However, Resident #68 had sustained a 6.9% (12.6 lbs) weight loss in one month from 1/3/24 to 2/5/24, which was considered severe. B. Observations On 5/21/24, lunch meal service was observed for the secured unit. Resident #68's meal ticket indicated the resident was on a regular diet. The serving size on his plate matched the regular diet serving on the meal ticket. During a continuous observation on 5/22/24, beginning at 12:09 p.m. and ending at 1:08 p.m., the following was observed in the secured unit dining room: At 12:25 p.m. Resident #68 was served his lunch. The meal ticket indicated the resident was on a regular diet. He consumed 100% of his lunch, dessert and the fluids that were provided to him. When his plate was empty, he picked up the plate and licked it until there was nothing left on his plate. From 12:44 p.m. until 12:51 p.m. Resident #68 picked up his empty cup and tried to drink out of it. He picked up his fork and attempted to eat off his empty plate. At 12:52 p.m. a certified nurse aide (CNA) #1 said to Resident #68 he must be hungry and asked if he wanted a snack. He said yes. CNA #1 gave the resident a fruit cup. At 12:59 p.m. Resident #68 finished eating the fruit cup. He drank the fruit juice that was in the bottom of the fruit cup. At 1:02 p.m. Resident #68 stood behind another resident who was sitting in the dining room eating her lunch, (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 1:07 p.m. Resident #68 moved to stand behind another resident who was eating her lunch. CNA #1 redirected Resident #68 by telling him to let the two residents eat their lunch. He followed CNA #1 out of the dining room. C. Record review The nutrition care plan, revised 3/19/24, revealed the resident had potential for altered nutrition due to increased poor vision and sporadic intake. The care plan indicated on 2/13/24 the resident had a poor appetite and his diet was changed to finger foods to improve intake. The care plan indicated on 3/19/24 the resident had mild weight gain after he had lost weight and was eating most of his meals. Interventions included providing the resident finger foods, providing supplements and providing the diet as ordered. -However, a review of Resident #68's electronic medical record (EMR) did not reveal the resident was prescribed a nutritional supplement. Resident #68's weights were documented in the resident's medical record as follows: -On 8/9/23, the resident weighed 201.8 pounds; -On 9/4/23, the resident weighed 197.0 pounds; -On 10/3/23, the resident weighed 194.4 pounds; -On 11/7/23, the resident weighed 196.0 pounds; -On 12/4/23, the resident weighed 182.2 pounds; -On 1/3/24, the resident weighed 183.4 pounds; -On 2/5/24, the resident weighed 170.8 pounds; -On 3/19/24, the resident weighed 173.0 pounds; -On 4/9/24, the resident weighed 173.6 pounds; and, -On 5/5/24, the resident weighed 172.0 pounds. -The resident lost 13.8 lbs (7%) from 11/7/23 to 12/4/23 in one month, which was considered severe weight loss. -The resident lost 12.6 lbs (6.9%) from 1/3/24 to 2/5/24 in one month, which was considered severe weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 10/19/23 hospital discharge summary revealed the resident was hospitalized from 10/13/23 to 10/19/23 for large bowel ischemia and necrosis of the colon. The resident had dementia and surgery was determined not to be in the resident's best interest. The resident was treated conservatively with antibiotics, intravenous fluids and pain medication. The family understood that the resident's abdominal process could happen again. If the resident's status worsened, the family was ready for hospice services. The resident was discharged with a regular diet. The 10/20/23 nursing progress note revealed the resident returned from the hospital. He did not have any complaints of abdominal pain. He asked for food and he ate soup without any issues. The 10/21/23 nursing progress note revealed the resident ate his breakfast well. He had an Ensure liquid nutritional supplement. The resident gagged and produced mucus. The Ensure was discontinued. The 12/5/23 RD progress note revealed the resident was on a fortified regular diet. The note documented the resident walked around the unit a lot of the day. The RD documented the resident was prescribed Olanzapine (a medication used to treat mental disorders). There were no recent labs to review and the resident's skin was intact. The resident had significant weight loss in 30 days. The resident had increased nutritional needs related to his height. The resident was consuming more than 94% of his meals. The note documented the resident likely was not meeting his nutrition needs. The RD requested large portions with all meals. The note documented the RD would continue to monitor the resident. -A review of the resident's EMR did not reveal documentation that large portions was added to the resident's diet order. -A review of the resident's comprehensive care plan did not reveal the intervention to provide the resident large portions was added the care plan. The 12/15/23 nursing progress note documented at 2:53 a.m. revealed Resident #68 took food off other resident's plates. He also took a quesadilla out of the trash can. The resident ate three slices of pecan pie and four glasses of juice. He returned to his room and settled into bed. The 12/27/23 nursing progress note revealed the resident paced and walked around the unit. The note documented the resident's jeans were too big and were constantly falling down. He said he was hungry and he ate two fruit cups. He ate well. At 10:30 p.m. he went to bed. The 2/9/24 quarterly dietary assessment revealed the resident was on a regular diet with regular portions. He had a poor appetite with his average intake of meals ranging from 25 to 50%. He had good hearing and good eyesight. He used regular utensils and required partial assistance with meals. -However, the resident was not observed to be provided assistance with his meals during the survey (see observations above). -The 2/9/24 quarterly dietary assessment did not address the resident's significant weight loss of 6.9% (12.6 lbs) from 1/3/24 to 2/5/24 in one month. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 3/19/24 RD progress note revealed the resident was reviewed by the interdisciplinary team (IDT) in an at-risk meeting. He was on a regular diet and finger foods provided. He required supervision with meals. His meal intake was 76% or more for one to three meals a day. The resident was not receiving an oral supplement at this time. The resident had significant weight loss in the last six months.The resident had mild weight gain in the last 30 days after the significant weight loss. The note documented further weight gain was desirable and the RD would continue to monitor the resident's weight. -However, the facility did not implement a person-centered nutrition intervention after the RD determined further weight gain was desirable for the resident. The 4/12/24 physician progress note revealed the resident's abdominal pain was evaluated. The resident was acting as though he was in pain. The resident was doing better this week. The note documented the resident required restraints and one on one care. Diagnostic testing confirmed a large liver cyst. The assessment and plan revealed the resident had generalized abdominal pain. The abdominal pain was stable. The main therapy would be pain control. -The 4/12/24 physician progress note did not address the resident's severe weight loss. The 5/14/24 quarterly dietary assessment revealed the resident had a regular diet with regular portions. He had a poor appetite and was consuming 25 to 50% of his meals. He had good hearing and good eyesight. He used regular utensils and required partial assistance with his meals. -However, Resident #68 was supposed to receive large portions according to the interview with the RD (see interview below). III. Staff interviews Certified nurses aide (CNA) #3 was interviewed on 5/22/24 at 3:52 p.m CNA #3 said Resident #68 had lost weight in October 2023 since he was having intestinal issues.She said the resident was ill, but was doing better. She said the resident ate everything on his plate and drank his fluids at most meals. Licensed practical nurse (LPN) #3 was interviewed on 5/22/24 at 3:59 p.m. LPN #3 said Resident #68 had a history of weight loss She said the resident had been hospitalized in October 2023 for an ischemic bowel and was not doing well at the time. She said since then the resident had improved and was eating and drinking everything he was served. The assistant director of nursing (ADON) was interviewed on 5/23/24 at 12:30 p.m. The ADON said when weight loss was identified the facility typically implemented nutritional interventions, which included liquid nutritional supplements, a fortified diet, double portions and speech therapy study. The ADON said the minimum data set coordinator (MDSC) was responsible to update the care plan after the ADON met with the RD to discuss potential nutritional interventions. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The ADON said Resident #68 went to the hospital in October 2023 for an ischemic bowel. The ADON said the family did not want the resident to have surgery. The ADON said the resident started antibiotics in the hospital and then returned to the facility. The ADON thought the hospital environment was not good for the resident because he had dementia. The ADON said the facility thought he was actively dying, because he was lethargic, in pain and was not able to eat food because of digestive system issues. She said the facility could adjust a diet if a resident was actively dying. The ADON said the facility switched electronic systems that managed all resident's diets. She said that was possibly one reason the resident did not receive large portions at lunch on 5/21/24 and 5/22/24. She said the facility could have put the resident on weekly weights to monitor the resident's weight status closer. She said the resident was not on weekly weights. The RD was interviewed on 5/23/24 at 11:48 a.m. The RD said dietary assessments were completed upon admission, quarterly and if there was a significant change in the residents condition. She said the dietary manager (DM) completed the quarterly assessments. She said when a resident was admitted to the facility they were weighed for three days, then weekly for three weeks and then monthly. She said when a resident had weight loss she reviewed the resident's meal intakes, acceptance of the liquid nutritional supplements and determined the root cause of the weight loss. She said the ADON was responsible for notifying the family and the physician regarding the weight loss. The RD said the resident was on a regular diet with finger foods. She said the resident's weight was stable since 2/5/24 with minor fluctuations. She said he lost weight initially because he had dementia. She said he needed more queuing and encouragement if he was not eating. She said the resident was not weighed weekly because his weight had been stable recently. She said it was not necessary to weigh him weekly. The RD said she last assessed the resident on 3/19/24. She said since admission, the resident had significant weight loss. The RD said the resident was supposed to receive fortified foods and large portions. She said the diet order was handled by the DM. The RD said she had told the DM to change the diet order on 12/9/23. She said there was a time when the facility did not have a DM, so the diet order could have been overlooked during that time. The director of nursing (DON) was interviewed on 5/23/24 at 10:23 a.m. The DON said the assistant director of nursing (ADON) and the RD were responsible for identifying severe weight loss and sending a formal recommendation of intervention to the IDT team. She said the ADON was responsible for notifying the RD when a resident had a significant weight loss. The DON said the physician was part of care planning on a weekly basis. The DON said typical interventions that were implemented after a significant weight loss were liquid nutritional supplements and a change in diet orders. The DON said Resident #68 used to eat everything that was left out on the kitchen counter and dining room table. She said the resident had a decrease in vision which could have contributed to his weight loss. She said the previous dietary manager (DM) no longer worked at the facility. She said the previous DM did not follow the portion sizes indicated on the meal extensions. She said she observed the previous DM underserve multiple residents on several occasions at meals. She said Resident #68 was supposed to have double portions and the resident's meal ticket needed to indicate he was to receive double portions at meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The DON said Resident #68 had a history of pretending to eat when there was nothing left on his plate. The DON said this was a behavior he displayed when he was still hungry. She said it was hard to identify a resident's needs when they had dementia. The DON said Resident #68 had triggered significant weight loss. IV. Facility follow up The MDSC sent a performance improvement plan to improve tracking, follow up and prevention of weight loss on 5/28/24 at 7:23 a.m. It revealed that the facility had four action plans. The action steps included to review all resident's weight trends to determine weight loss and risk, review and update care plans based on weight review and educate nursing staff on what to document for weight loss and monitor resident meals. -The follow-up did not include dates when the action steps were completed.

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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** 47150 Based on observations, record review, and interviews, the facility failed to use a person-centered approach when determining the use of bed rails for eight (#1, #33, #36, #44, #18, #25, #41, and #53) of seventeen residents reviewed for bed rails out of 33 sample residents. Specifically, for Resident #1, #33, #36, #44, #18, #25, #41 and #53, the facility failed to: -Assess the resident for risk of entrapment prior to installing the bed rails; -Obtain consent, which included the risks versus benefits of bed rails, from the resident and/or the resident's representative prior to bed rail installation; -Obtain physician's orders for bed rails; and, -Conduct quarterly assessments of the bed rails to evaluate the continued need and safety of the bed rails. Findings include: I. Professional reference The U.S. Food and Drug Administration (FDA) Recommendations for Health Care Providers Using Adult Portable Bed Rails (2/27/23), was retrieved on 5/28/24 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health- care-providers-using-adult-portable-bed-rails. It read in pertinent part, Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. II. Facility policy and procedure The Bed Safety and Bed Rails policy and procedure, revised August 2022, was provided by the nursing home administration (NHA) on 5/22/24 at 2:00 p.m. It read in pertinent part, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents' beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bedrails are prohibited unless the criteria for use have been met. Consideration is given to the residents' safety, medical conditions, comfort and freedom of movement, as well as input from residents and resident families regarding previous sleeping habits and bed environment. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. The maintenance department provides a copy of inspections to the administrator and reports results to the Quality Assurance and Performance Improvement (QAPI) committee for appropriate action. III. Resident #1 A. Resident status Resident #1, under age 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis, dementia, contracture of muscle and chronic respiratory failure. The 2/28/24 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. He was dependent on staff assistance with transfers, toileting personal hygiene and mobility. -The assessment documented Resident #1 did not use bed rails. B. Observations On 5/20/24 at 9:40 a.m., Resident #1 was observed lying in bed with two metal half rails attached to the resident's bed. On 5/21/24 at 2:35 p.m. Resident #1 was observed to be lying in bed with the two metal half rails up on the bed. C. Resident interview Resident #1 was interviewed on 5/22/24 at 10:57 a.m. Resident #1 said the bed rails were used to help him roll left and right side when the staff changed his briefs. He said the bed rails had been in place for a long time. D. Record review The May 2024 CPO revealed Resident #1 had a physician's order for a set of half side rails on each side of the bed to help aid with mobility, ordered on 3/9/18. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan, initiated on 3/7/18 and revised on 1/9/19, revealed Resident #1 used half side rails to his bed related to multiple sclerosis. Interventions included Resident #1 holding on to the bed rails to assist with turning and repositioning. -A comprehensive review of the resident's electronic medical record (EMR) failed to reveal a bed rail evaluation and consent prior to the initiation of the bed rails as a positioning enabler. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the half bed rails. -The maintenance department had no routine inspections for the resident's half bed rails. IV. Resident #33 A. Resident status Resident #33, over the age 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included multiple sclerosis, dementia, major depressive disorder, lower back pain and chronic obstructive pulmonary disease (COPD). The 3/19/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She required set up assistance with toileting, showering, dressing, personal hygiene and mobility. -The assessment documented Resident #33 did not use bed rails. B. Observation On 5/20/24 at 10:36 a.m. and on 5/21/24 at 3:02 p.m., a bed rail was observed on the left side of Resident #33's bed. C. Resident interview Resident #33 was interviewed on 5/22/24 at 11:05 a.m. Resident #33 said the bed rail had been on her bed for a very long time. The resident said she does not know the reason the bed rail was attached to her bed because she does not use it. D. Record review The care plan, initiated on 4/19/24 and revised on 10/10/23, revealed Resident #33 was at risk for falls related to multiple sclerosis and abnormality of gait. Interventions included the use of a bedside rail for mobility. -Review of Resident #33's May 2024 CPO revealed there was no physician's order for the resident's bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's EMR revealed Resident #33 was not evaluated for the use of a bed rail, there was no consent for bed rails and no documentation about the risks and benefits of using a bed rail. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rail. -The maintenance department had no routine inspections for the resident's bed rail. V. Resident #36 A. Resident status Resident #36, over the age 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included cerebral infarction (a condition that occurs when brain tissue is damaged), type 2 diabetes and depressive disorder. The 2/22/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. She required set up assistance for oral and personal hygiene, substantial to maximum assistance with showers, dressing, and was dependent on staff with toileting. -The assessment documented Resident #36 did not use bed rails. B. Observation On 5/20/24 at 9:14 a.m. and on 5/21/24 at 2:15 p.m. Resident #36 was lying in her bed. Bed rails were observed on both sides of the resident's bed. C. Resident interview Resident #36 was interviewed on 5/22/24 at 1:04 p.m. Resident #36 said the bed rails were for her to hold on to to assist her with turning herself during incontinent care. D. Record review The resident care plan, revised on 5/24/21, revealed Resident #36 had a mobility deficit related to stroke and cognitive impairment as evidenced by difficulty with bed mobility requiring the use of bed rails. -Review of Resident #36's May 2024 CPO revealed there was no physician's order for the resident's bed rails. -The resident's EMR revealed Resident #36 was not evaluated to use a bed rail, there was no consent and no documentation about the risks and benefits of using a bed rail. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rails. -The maintenance department had no routine inspections for the resident's bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VI. Resident #44 A. Resident status Resident #44, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized CPO, diagnoses included Alzheimer's disease, myxedema coma (severe hypothyroidism leading to decreased mental status, hypothermia, and other symptoms related to slowing of function in multiple organs), insomnia and muscle weakness. The 4/30/24 MDS assessment documented the resident had severe cognitive impairment with a BIMS score of four out of 15. She required partial assistance with showering and supervision with toileting and personal hygiene. -The assessment documented Resident #44 did not use bed rails. B. Observation On 5/20/24 at 3:30 p.m., 5/21/24 at 8:57 a.m. and 5/22/24 at 10:30 a.m. bed rails were observed on both sides of Resident #44's bed. C. Record review The care plan, revised on 4/12/24, revealed Resident #44 had an activity of daily living (ADL) self care performance deficit related to Alzheimer's disease. -Bed rails were not included in the resident's care plan interventions. -Review of Resident #44's May 2024 CPO revealed there was no physician's order for the resident's bed rails. -The resident's EMR revealed Resident #44 was not evaluated to use a bed rail, there was no consent and no documentation about the risks and benefits of using a bed rail. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rails. -The maintenance department had no routine inspections for the resident's bed rails. VII. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 5/22/24 at 9:14 a.m. CNA #5 said the bed rails were handles added to the sides of the bed. She said bed rails helped a resident, if used appropriately, for bed mobility and when the resident got in and out of bed. CNA #5 said the resident held on to the bed rails during incontinence care. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #4 was interviewed on 5/22/24 at 9:32 a.m. LPN #4 said the bed rails were used when residents were alert and oriented and could help themselves instead of waiting for a staff member to help them. She said a resident should be evaluated for safety before using the side rail. She said the evaluation was based on the residents' level of care based on their everyday needs. LPN #4 said consent should be obtained from the resident or resident's representative prior to use of the bed rails. The director of nursing (DON) was interviewed on 5/22/24 at 2:15 p.m. The DON said, before side rails could be used, a bed rail evaluation and consent needed to be completed. However, she said the facility did not consider the bed rails as a form of restraint, therefore the facility did not perform evaluations and did not obtain consent from the residents. The DON said the facility did not have a formal document to show maintenance staff routine inspections of all bed rails for a potential entrapment risk. The DON said the facility would immediately ensure consent and evaluations were completed. 47350 VIII. Resident #18 A. Resident status Resident #18, age over 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD) and dementia. The 1/23/24 MDS assessment revealed the resident was cognitively intact with a BIMS of 13 out of 15. She required partial/moderate assistance with transfers and toileting, set up assistance with personal hygiene and was independent with eating and bed mobility. -The assessment indicated that restraints and bed rails were not used. B. Observations On 5/23/24 at 8:00 a.m. Resident #18 was observed with a bed rail on her bed. C. Record review The activities of daily living (ADL) care plan, initiated on 2/21/22 and revised 9/1/22, revealed Resident #18 used a halo assistive device (bed rail) on the door side of the bed to maximize independence with turning and repositioning in bed. -A comprehensive review of the resident's EMR failed to reveal a bed rail evaluation, physician's order or consent done prior to the initiation of the bed rail as a positioning enabler. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IX. Resident #25 A. Resident status Resident #25, age less than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included encephalopathy and protein malnutrition. The 2/22/24 MDS assessment revealed severe cognitive impairment with a BIMS score of zero out of 15. He was dependent with toileting and personal hygiene, required substantial/maximal assistance with bed mobility and transfers and required supervision with eating. -The assessment indicated that restraints and bed rails were not used. B. Observation On 5/23/24 at 8:02 a.m. Resident #25 was observed with bed rails on his bed. C. Record review The ADL care plan, initiated on 6/10/23 and revised on 2/27/24 revealed Resident #25 had a bed rail on his bed for assistance with positioning. The May 2024 CPO revealed a physician's order for bilateral bed rails to be used for positioning, ordered 2/22/23. -A comprehensive review of the resident's EMR failed to reveal a bed rail evaluation prior to the initiation of the bed rails. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rail. X. Resident #41 A. Resident status Resident #41, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included CKD, chronic respiratory failure and vascular dementia. The 2/1/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. She required substantial/maximal assistance with transfers, partial/moderate assistance with personal hygiene, bed mobility, toileting and was independent with eating. -The assessment indicated that restraints and bed rails were not used. B. Observations On 5/23/24 at 8:04 a.m. Resident #41 was observed with a bed rail on her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The ADL care plan, initiated on 8/11/23 and revised on 3/6/24, revealed Resident #41 required partial/moderate assistance of one staff member for bed mobility. -The care plan failed to indicate the use of bed rails as an intervention as a positioning enabler. -A comprehensive review of the resident's EMR failed to reveal a bed rail evaluation, physician's order or consent done prior to the initiation of the bed cane/halo as a positioning enabler. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rail. XI. Resident #53 A. Resident status Resident #53, age 80, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included atrial fibrillation, pancreatic insufficiency and cognitive communication deficit. The 4/11/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. She required partial/moderate assistance for toileting, supervision with bed mobility, transfers and was independent with eating, personal hygiene. -The assessment indicated that restraints and bed rails were not used. B. Observations On 5/23/24 at 8:06 a.m. Resident #53 was observed with a bed rail on her bed. C. Record review The ADL care plan, initiated on 5/12/23 and revised on 1/31/24, revealed Resident #53 was able to roll side to side in bed and go from sitting to lying and lying to sitting with the partial/moderate assistance of one staff member. -The care plan failed to indicate the use of bed rails as an intervention as a positioning enabler. -A comprehensive review of the resident's EMR failed to reveal a bed rail evaluation, physician's order or consent done prior to the initiation of the bed cane/halo as a positioning enabler. -The EMR failed to reveal quarterly assessments for the evaluation of the continued use and safety of the bed rail. XII. Staff interviews CNA #2 was interviewed on 5/23/24 at 8:30 a.m. CNA #2 said Residents #18. #25. #41 and #53 all used bed rails as bed mobility positioning or bed transferring devices. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #2 was interviewed on 5/23/24 at 8:34 a.m. LPN #2 said residents with bed rails should all have an assessment by occupational or physical therapy for their use of the bed rails. She said the resident or the resident's representative should give consent for the bed rails prior to their use. She said an order should be placed before the bed rails were used. She said bed rails should have a regular assessment by maintenance to maintain the safety and functionality of their use. She said she was new to the facility and was unfamiliar with the facility's policies and procedures.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47350 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in accordance with professional standards on two of four units. Specifically, the facility failed to: -Ensure Tuberculin purified protein derivative (PPD) was dated after opening; and, -Ensure refrigerated medications were stored in a sanitary manner, separately from refrigerated food items. Findings include: I. Professional reference According to the Sanofi Pasteur (2020) package insert for Tuberculin Purified Protein Derivative (Mantoux): Tubersol Food and Drug Administration (FDA), retrieved on 5/31/24 from https://www.fda.gov/media/74866/download, A vial of Tubersol (tuberculin purified protein derivative) which has been entered and in use for 30 days should be discarded. Do not use it after the expiration date. II. Facility policy and procedure The Storage of Medications policy and procedure, reviewed 2/17/23, was provided by the director of nursing (DON) on 5/23/24 at 10:00 a.m. It read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Refrigerated medications are stored separately from food and are labeled accordingly. III. Observations On 5/22/24 at 2:11 p.m. unit medication refrigerator #1 was observed with registered nurse (RN) #1. The following items were found: -A vial of Tubersol PPD was opened and undated. -A vial of Tubersol was dated as opened on 4/12/24. The vial should have been discarded on 5/12/24. -Several unopened nutritional supplement drinks and unopened soda drinks were in the medication refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 2:15 p.m. unit medication refrigerator #2 was observed. The following items were found: -Multiple unopened yogurt and pudding cups. -One opened med pass shake was lying on its side at the bottom of the refrigerator. -Bisacodyl suppositories, eye drops and probiotic containers were stored on the top shelf of the refrigerator. IV. Staff interviews RN #1 was interviewed on 5/22/24 at 2:14 p.m. RN #1 said nutritional supplements, as long as they were not opened, could be stored in the same refrigerator with the medications. She said she was not sure if soda could be stored in the refrigerator with nutritional supplements. RN #1 said it was not good practice to store food items and beverages with medications. She said tuberculin should be dated after opening and was only good for 30 days after opening, per the manufacturer's directions. The assistant director of nursing (ADON) was interviewed on 5/22/25 at 2:18 p.m. The ADON said food items should not be stored with medications and tuberculin should be dated so it could be identified when it needed to be discarded. She said the manufacturer's recommendation was to discard it after 30 days. She said storing medications and food and beverage items together was not a sanitary practice. The nursing home administrator (NHA) was interviewed on 5/22/24 at 2:18 p.m. The NHA said storing medications and beverages and food items in the same refrigerator was not a sanitary practice and the facility would order additional refrigerators to keep medications and food items separate.

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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. 47150 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure temperatures were taken of refrigerators in the main kitchen; and, -Have a system in place to monitor the internal temperature of the dishwasher to ensure the functioning of the dishwasher. Findings included: I. Professional reference According to the Food and Drug Administration Food Code (2022), retrieved on 5/28/24 from https://www.fda.gov/media/164194/download?attachment, Water temperature is critical to sanitization in ware washing operations. This is particularly true if the sanitizer being used is hot water. A temperature measuring device is essential to monitor manual ware washing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the ware washing machine meet or exceed the required 160 degrees F (Fahrenheit). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical ware washers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 160 degrees). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 160 degrees F. II. Facility policy and procedure The Refrigerator, Freezer and Dishwashing policy, revised in 2009, was provided by the nursing home administrator (NHA) on 5/22/24 at 11:00 a.m. It read in pertinent part, The facility will ensure safe refrigerators and freezers maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Acceptable temperatures should be 35 degrees to 40 degrees Fahrenheit (F) for refrigerators and below zero degrees F for freezers. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. Monthly tracking sheets will include time, temperature, initials, and action taken. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Food Service Supervisor or designated employees will check and record refrigerator and freezer temperatures daily with the first opening and at closing in the evening. The dishwasher operator will check temperatures using the dishwasher gauge with each washing cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during the dishwashing machine cycle. III. Observations and interviews On 5/20/24 at 8:43 a.m. dietary aide (DA) #2 put a load of dishes through the dishwasher. He said the dishwasher was high temperature and indicated that the external temperature gauge displayed 180 degrees F. He said there was not a temperature log to record the dishwasher temperatures (see record review below). DA #2 said he did not know how to check the internal temperature of the dishwasher to ensure the temperature on the outside display was correct. He said the facility did not keep a log of the temperature of the dishwasher. IV. Record review A request was made for the dishwasher temperature log on 5/20/24. DA #2 said the facility did not utilize temperature logs (see interview above). A review of the temperature log that was hung outside the main kitchen's walk-in refrigerator and freezer on 5/22/24 revealed the log was missing 21 of 46 opportunities to monitor the walk-in refrigerator and freezer temperatures on the May 2024 (from 5/1/24 to 5/22/24) walk-in refrigerator and walk-in freezer temperature log. V. Staff interviews DA #1 was interviewed on 5/22/24 at 1:16 p.m. DA #1 said the kitchen had recently gotten a new dishwashing machine. DA #1 said the former dietary manager (DM) explained to her verbally how to operate the dishwasher. DA #1 said she did not remember the appropriate recommendations for a high-temperature dishwasher. She said the facility used to have a log for the dishwasher but she said she did not know why they did not have it now. She said she had not seen the temperature log for the dishwasher for a while. The DM was interviewed on 5/22/24 at 1:35 p.m. The DM said the dining staff members needed to monitor the temperature of the dishwasher on a regular basis and put it on a log to ensure the dishwasher was functioning properly. The DM said it was necessary to monitor the temperature to ensure proper sanitation of the dishes to prevent bacterial growth. She said the temperature logs for the main kitchen walk-in refrigerator and the walk-in freezer were missing temperatures. She said the temperature of the refrigerator and freezer needed to be monitored on a regular basis to ensure they were maintaining the correct temperature. The DM said she would immediately initiate training for all of the kitchen staff on obtaining and documenting daily temperatures of the walk-in refrigerator and freezer. She said she would also provide education on how to monitor and log the temperatures of the dishwasher.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47350 Based on observations, interviews and record review, 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 and infection in four of four units. Specifically, the facility failed to -Ensure clean technique was followed during wound care for Resident #56; and, -Ensure the facility had an active Legionella water management plan in place to prevent or reduce Legionella in the facility. Findings include: I. Clean technique during wound care A. Facility policy and procedure The Wound Care policy and procedure, revised October 2010, was provided by the director of nursing (DON) on 5/23/24 at 8:30 a.m. It read in pertinent part, Use disposable cloth to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field. Put on exam gloves. Loosen tape and remove dressing. Pull gloves over the dressing and discard it into the appropriate receptacle. Wash and dry hands thoroughly. Be certain all clean items are on a clean field. B. Observations Licensed practical nurse (LPN) #1 was observed providing wound care, with the assistance of DON, to Resident #56's right foot wound on 5/22/24 at 10:00 a.m. LPN #1 placed a trash bag onto Resident #56's bed with the clean supplies on top of it. -LPN #1 did not establish a clean field separate from Resident #56's bed and placed clean supplies on a trash bag directly on the bed. LPN #1 removed the dressing and placed the old dressing onto the trash bag on the bed next to the clean supplies. -LPN #1 placed a dirty dressing next to clean dressing supplies on a non clean field. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LPN #1 picked up the wound cleanser bottle, opened a gauze dressing lying on the trash bag and sprayed wound cleanser onto the wound and wiped it with a gauze dressing. -LPN #1 did not change gloves or perform hand hygiene after removing the old dressing and before touching clean supplies and cleaning the wound. LPN #1 opened up a betadine swab and swabbed around edges of the wound and disposed of the betadine swab onto the trash bag that was lying on the bed with the wound supplies on top of it. -LPN #1 opened the clean betadine swab that was lying on the trash bag next to the soiled dressings and disposed of the used swab back onto the trash bag that contained the soiled dressing and clean supplies. LPN #1 did not change gloves and perform hand hygiene before handling the betadine swab. LPN #1 picked up a skin prep package and opened it and swabbed around the edges of the wound. -LPN #1 did not change her gloves and perform hand hygiene before handling the clean skin prep pad. LPN #1 picked up a gauze dressing package from the trash bag and opened the package. She placed the open gauze package back on the trash bag. She then changed her gloves and performed hand hygiene -LPN #1 did not change her gloves or perform hand hygiene before touching the clean gauze dressing and placed the opened gauze package down onto the non clean field. LPN #1 picked up the open gauze package and placed the gauze onto the wound. -Throughout the wound observation, LPN #1 did not maintain a designated clean field that kept clean wound supplies separate from dirty dressings and supplies. She did not perform hand hygiene or change gloves after touching dirty dressings or supplies. C. Staff interviews The DON was interviewed on 5/22/24 at 10:15 a.m. The DON said when performing a clean technique, a clean field for clean supplies should be maintained and kept separate from dirty dressings and supplies. She said after a nurse removed a soiled dressing or touched soiled supplies, the nurse should change their gloves and perform hand hygiene. The DON said during Resident #56's wound care, LPN #1 should have set-up and maintained a clean field. She said the clean supplies should have been kept separate from the soiled dressings and supplies. She said the nurse should perform hand hygiene and put on clean gloves after touching a dirty dressing or wound supply item and before cleaning or applying a new dressing to a wound. The DON said changing gloves and performing hand hygiene frequently helped prevent cross contamination of organisms from soiled to clean. She said she would review clean technique with LPN #1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LPN #1 was interviewed on 5/22/24 at 10:20 a.m. LPN #1 said she did not set-up a clean field correctly for Resident #56's wound care. She said she should have had a separate clean field established. She said clean wound supplies should be kept on the clean field and dirty items should not be mixed with clean wound items. She said after removing a dirty dressing, touching soiled supplies or after cleaning a wound hand hygiene should be performed and gloves changed. II. Legionella water management A. Professional reference The Centers for Disease Control (CDC). (6/24/21). Developing a Water Management Program to Reduce Legionella Grown and Spread in Buildings. U.S. Department of Health and Human Services was provided by the minimum data set coordinator (MDSC) on 5/23/24 at 10:00 a.m. It read in pertinent part, Legionnaires disease is a serious type of pneumonia caused by bacteria, called Legionella, that lives in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. B. Facility policy and procedure The Legionella Water Management Program policy and procedure, revised September 2022, was provided by the minimum data set coordinator (MDSC) on 5/23/24 at 10:00 a.m. It read in pertinent part, As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. The water management team consists of at least the following personnel: infection preventionist, administrator, medical director (or designee), director of maintenance and director of environmental services. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaires disease. C. Record review A request was made for the water management monitoring and testing on 5/23/24. -The facility was unable to provide documentation of water management monitoring or testing for the facility. D. Staff interviews The infection preventionist (IP) was interviewed on 5/23/24 at 8:45 a.m. The IP said she was not involved in the water management program for Legionella and she did not know if a water management program was in place. She said the environmental services director (ESD) would have the records of the water management program and testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ESD was interviewed on 5/23/24 at 9:30 a.m. The ESD said he was new to his role and was not aware of a water management program for Legionella for the facility. He said he received a report from the city regarding water quality outside of the facility but did not have documentation of water monitoring or testing for Legionella for the facility. He said he was not aware that a water management program needed to be in place to help reduce or prevent Legionella within the facility. The nursing home administrator (NHA) was interviewed on 5/23/24 at 9:40 a.m. The NHA said she had recently started working at the facility. She said it had been identified by the medical director at a recent quality assurance and performance improvement (QAPI) meeting that a Legionella water management program needed to be in place at the facility. She said the facility did not have an active water management program in place yet. She said they were using the CDC guidelines in implementing the Legionella water program. She said this program was necessary to help prevent Legionella in the facility.