STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A172	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Forest Care Center, Inc.	7045 Stuart St Westminster, CO 80030

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to make prompt efforts to resolve resident grievances brought up by the resident council. Findings include: I. Facility policy and procedure The Grievance policy, reviewed 5/13/25, was provided by the nursing home administrator (NHA) on 6/3/25 at 6:51 a.m. It read in pertinent part, All grievances are forwarded to the grievance official and a written acknowledgment is provided to the complainant within three calendar days of receipt. The grievance official conducts a prompt investigation. Written resolution is provided within 14 calendar days. If more time is needed, interim updates are provided, with justification for delay. II. Resident group interview Five alert and oriented residents (#65, #33, #18, #76 and #39) who regularly attended the resident council meetings were interviewed on 6/2/25 at 1:00 p.m. The residents were identified as alert and oriented through facility and assessment. The group of residents said the facility did not follow up on grievances brought up in the resident council meetings. Resident #76 said when a grievance came up in the resident council meeting the department head tried to address it during the meeting but the manager did not complete a grievance form. Resident #65 said if it was an individual grievance, the department head would follow-up with the individual resident. Resident #65 said if it was a group grievance a resolution was not consistently brought back to the next resident council meeting by the facility. III. Record review (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident council meeting minutes, dated 3/6/25, revealed the residents brought up concerns regarding the men's section of the building needing increased heat, an individual resident needing a call light, short staffing, lazy night staff and requests for increased activities. -Review of the March 2025 resident council minutes did not reveal documentation indicating the facility had addressed the residents' concern. A review of the resident council meeting minutes, dated 4/3/25, revealed the residents brought up concerns regarding long call light times, cold shower water, short nursing staff, adding more vegetarian options for meals, limited snack options, increased lighting outside of the building, an individual resident's complaint of low toilets and an individual residents complaint regarding problems with wheelchair wheels. -Review of the April 2025 resident council minutes did not reveal documentation indicating the facility had addressed the residents' concerns. A review of the resident council meeting minutes, dated 5/1/25, revealed the residents brought up concerns regarding the need for improvements in taking resident's food orders, ensuring personal items, like newspapers, were not thrown away by housekeeping, requests for maintenance to install locks on drawers for individual residents, and and an individual residents complaint regarding problems with wheelchair wheels. -Review of the May 2025 resident council minutes did not reveal documentation indicating the facility had addressed the residents' concern. IV. Staff interviews The social services director (SSD) was interviewed on 6/2/25 at 3:15 p.m. The SSD said she facilitated the resident council meetings and the facility had a process for addressing individual resident grievances but there was not a process for following up on group grievances generated during resident council. She said the manager present at the meeting whose department would be responsible for the grievance, would talk about how they planned to resolve it in the meeting. The SSD said if the concern involved a maintenance issue, the maintenance director would initiate a work order to resolve the concern. V. Facility follow up The NHA sent an email on 6/3/25 at 10:03 a.m. with evidence of work orders as follows; A work order, dated 3/6/25, for the individual resident who needed a call light and had complaints regarding a low toilet. A work order, dated 4/3/25, for the individual resident with wheelchair wheel complaints. A work order, dated 5/2/25, for lock installation on drawers for the residents who requested the locks and housekeeping education regarding disposing of resident items like newspapers. -No grievances or evidence of resolution was provided for any other resident council grievances.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to coordinate changes to the preadmission screening and resident review (PASRR) Level II determination and evaluation report promptly with the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#38) of two residents reviewed for PASRR out of 35 sample residents. Specifically, the facility failed to notify the State Mental Health Agency when a resident received a new diagnosis (bipolar disorder) of a serious mental disorder for a PASRR Level II evaluation. Findings include: I. Facility policy and procedure The PASRR Evaluation and Screening policy, reviewed 1/29/25, was provided by the nursing home administrator (NHA) on 6/3/25 at 6:51 a.m. It read in pertinent part, Re-screening is required for; a new or changed psychiatric diagnoses, addition or change in psychotropic medication, or worsening behavioral or cognitive symptoms. II. Resident status Resident #38, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included unspecified dementia with behavioral disturbances (dated 1/14/22) and bipolar disorder (dated 7/18/24). The 4/17/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS condition list indicated the resident did not have a PASRR Level II diagnosis of major mental illness. III. Resident interview Resident #38 was interviewed on 5/28/25 at 10:35 a.m. She said she was unaware she had been diagnosed with bipolar disorder. IV. Record review The mood care plan, revised 1/23/25, revealed the resident used psychotropic medications related to dementia with behaviors. Interventions, dated 11/14/24, included administering medication as ordered, providing education to the resident on risks and benefits of the medication, and monitoring behaviors and interventions. The May 2025 CPO revealed the following physician orders: -Olanzapine (an antipsychotic medication) 10 milligrams (mg). Give one tablet by mouth at bedtime for dementia with behaviors, ordered on 3/27/25. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse practitioner visit note, dated 12/8/23, revealed a new diagnosis of unspecified bipolar disorder. The NP visited the resident at the residents request related to a urinary tract infection (UTI). -Review of Resident #38's electronic medical record (EMR) did not reveal documentation for the basis of the new diagnosis V. Staff interviews The social services director (SSD) was interviewed on 6/2/25 at 3:15 p.m. The SSD said she had not been able to find supportive documentation for the physician's diagnosis of bipolar disorder on 12/8/23 or the addition of bipolar disorder to Resident #38's EMR on 7/18/24. The SSD said when she reviewed the care plans for each resident quarterly, she also reviewed the diagnosis list. She said Resident #28's care plan was reviewed on 8/4/24, 10/28/24, 1/28/25, 2/4/25 and 4/30/25, however she said she had not identified the resident's new diagnosis during those reviews or completed an updated PASRR screening. VI. Facility follow up The NHA provided documentation pertaining to Resident #38's bipolar disorder diagnosis on 6/2/25 at 5:12 p. m. (during the survey). The documentation provided included the following: -An authorization to clarify diagnosis, dated 5/30/25 (during the survey), signed by the physician striking out bipolar disorder from Resident #38's EMR due to lack of history; A submission of a new PASRR screening, dated 5/30/25 (during the survey); and, -An automated notice of determination response to the PASRR screening, dated 5/30/25 (during the survey), revealing she did not trigger for a major mental illness or Level II condition.

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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** IV. Resident #133 A. Resident status Resident #133, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbances and attention-deficit hyperactivity disorder. The 5/22/25 minimum data set (MDS) assessment revealed that Resident #133 was severely cognitively impaired and unable to participate in the brief interview for mental status (BIMS) assessment. According to the staff assessment for mental status, Resident #133 had short term and long term memory deficits, severely impaired decision making skills and continuous disorganized thinking. Resident #133 was not cognitively orientated to staff names and faces, where his room was or what type of facility he was in. He was independent in his activities of daily living (ADL) and ambulated independently. The MDS assessment indicated Resident #133 had not displayed any wandering behaviors within the seven day assessment look back period. -However, Resident #133 eloped from the facility on 5/19/25 (see record review and interviews below). B. Resident interview and observation Several attempts were made to interview Resident #133 on 5/29/25, however the resident became frustrated when questioned and was only able to answer questions related to how his day was going. He was ambulatory and wandering the hallways aimlessly. On 6/2/25 at approximately 4:30 p.m. Resident #133 was in his room. He was not wearing a wanderguard on either of his wrists or on his ankles. The resident did not understand what the wanderguard was and could not say where his wanderguard had gone. C. Record review The cognition care plan, dated 5/29/25 (during the survey), revealed Resident #133 was at high risk for exploitation, neglect or harm related to an inability to advocate for himself. Resident #133 was highly vulnerable due to significant cognitive impairments. He had difficulty understanding or responding to social cues, making him more vulnerable to inappropriate behavior by others. Interventions, dated 5/29/25 (during the survey), included to ensure the room and common areas were arranged to promote safety, assign consistent caregivers as much as possible, and ensure the resident had a clear way to report concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The elopement care plan, revised 5/29/25 (during the survey), revealed Resident #133 was an elopement/wanderer risk due to being disorientated to place and a decreased safety awareness. Interventions, revised 5/19/25, included assessing the resident for falls, providing distraction by offering pleasant distractions, and applying a wander alert (wanderguard) to the resident's right hand. Review of Resident #133's May 2025 CPO revealed the following physician orders: Wanderguard to the right hand. Monitor for functioning and placement two times a day for wandering, ordered 5/15/25 and discontinued 6/3/25 (during the survey). A narrative progress note, dated 6/3/25 (during the survey), revealed Resident #133 had a wanderguard device on 6/2/25 and removed it. The device was replaced at 6:00 p.m. (on 6/2/25). At 7:00 a.m. on 6/3/25, it was discovered that Resident #133 had cut his wanderguard device off a second time. The wanderguard was discontinued and 15-minute checks were started, per the resident's preference. -There was no documentation to indicate the resident had gone to an exit door, requiring him to be redirected from attempting to leave by staff, after removing his wanderguard device on 6/2/25 (see RN) #2 interview below). -Additionally, the progress note failed to identify how the 15-minute checks would be effective in keeping the resident safe. An exit seeking/elopement assessment, dated 5/19/25, revealed Resident #133 had requested to take a walk and then stated he was leaving the facility. An unidentified staff member followed him outside and was able to converse with him about general topics. The staff member was unable to redirect Resident #133 back to the facility, and he began walking towards the main road. The staff member walked with him and was finally able to redirect Resident #133 to a nearby store and then back to the facility. The social services director (SSD) reached out to Resident #133's sister to discuss filing for guardianship and completing a health care proxy (a document giving health care decisions to a designated individual after a physician determines the individual to lack capacity to make decisions). The 5/19/25 exit seeking/elopement assessment scored Resident #133 as a low risk for elopement. -However, the resident physically eloped from the facility on 5/19/25. -Review of Resident #133's EMR failed to reveal any additional exit seeking/elopement assessments, despite the fact that the resident removed his wanderguard device twice, once on 6/2/25 and again on 6/3/25, and declined to allow staff to replace the device on 6/3/25 (see above). Review of the CNA behavior charting for Resident #133, from 5/14/25 to 6/3/25, failed to reveal documentation of the resident wandering on 5/19/25 or 6/2/25. -However, Resident #133 actually exited the facility on 5/19/25 and was redirected away from an exit door by facility staff on 6/2/25 (see record review above and RN #2 interview below). D. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 6/2/25 at 9:45 a.m. RN #2 said Resident #133 had behaviors of wandering aimlessly. She said he would go to the exit doors but the sound of the wanderguard alarm deterred him from trying to leave. She said Resident #133 would stand by the door daily and could be redirected momentarily but would return to the door and was confused as to why he was living in the facility. RN #2 said the nurses checked his wanderguard device twice a shift to ensure it was functional and in place. CNA #3 was interviewed on 6/2/25 at 11:31 a.m. CNA #3 said Resident #133 had behaviors of wandering aimlessly but was pleasant and redirectable. The SSD was interviewed on 6/2/25 at 3:15 p.m. The SSD said Resident #133 had behaviors of exit seeking and attempting to go out of the front door so he had a wanderguard device. The SSD said Resident #133 wandered aimlessly and had severely impaired cognition. RN #2 was interviewed again on 6/3/25 at 11:22 a.m. RN #2 said Resident #133 had removed his wanderguard the previous day (6/2/25) and had gone to one of the exit doors where staff had to redirect him from attempting to leave. RN #2 said he did not want the wanderguard back on so he was placed on 15-minute checks. She said she did not know if a new exit seeking/elopement assessment should be completed because she was new to the facility. The DON was interviewed on 6/3/25 at 3:00 p.m. The DON said Resident #133 had a wanderguard placed on him initially when he was admitted on [DATE] because the hospital had advised the facility that he might have difficulty adjusting to placement, he had been living at home alone after his spouse passed away and then was evicted. She said he was only cognitively orientated to himself and could not tell the facility very much information. The DON said if Resident #133 were to leave the facility, he would be at high risk of becoming lost due to his cognitive impairment. The DON said 6/2/25 was the first time Resident #133 had removed his wanderguard but the facility was not sure how that occurred. The DON said she thought he might have figured out how to cut it off when he was out of the facility with the activities staff on a shopping trip. She said she did not know what the long term interventions were going to be for Resident #133's wandering. She said the immediate intervention was 15-minute checks but she said the facility had not assessed him for alternative interventions. The DON and the NHA were interviewed together on 6/3/25 at 6:30 p.m. The DON said Resident #133 would become overstimulated and confused at times. She said Resident #133 had gone out to the store with the activities staff and found a way to cut off his wanderguard while at the store. The DON said Resident #133 wandered the facility aimlessly and if he continued to show exit seeking behaviors, the facility would have to discharge him to a secure long term care facility. The NHA said Resident #133 had initially perseverated on leaving the facility when he first admitted , but recently had told staff the facility was his home. She said Resident #133 let the facility place a wanderguard on his wrist again on 6/2/25 after removing it, but then he took it off again. The NHA said Resident #133 told her, on 6/3/25, that he would not wear his wanderguard. She said she did not know how he was able to remove his wanderguard the second time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the facility did not complete a new exit seeking/elopement assessment after the resident's removal of his wanderguard or his attempt to leave on 6/2/25 because they initiated 15-minute checks. The NHA could not explain how the 15-minute checks were effective or why the facility initiated 15-minute checks instead of completing a new assessment to determine what effective supervision would work best for Resident #133 in order to keep the resident safe from further elopements. III. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (MS), obstructive sleep apnea, seizures, major depressive disorder, dementia, age related osteoporosis and contracture of muscle. The 2/25/25 minimum data set (MDS) assessment revealed the resident had a memory problem, moderately impaired-decisions poor and required cues/supervision. The resident was dependent on staff for all activities of daily living (ADL). B. Resident representative interview The resident's representative was interviewed on 5/29/25 at 9:13 a.m. The representative said Resident #9 was a fall risk and that she needed lifting and transfer assistance. C. Observations During a continuous observation on 5/29/25 beginning at 12:37 p.m. and ending at 2:05 p.m., the following observations were made: Resident #9 was in bed without the fall mat beside her bed throughout the entire continuous observation. -Several unidentified staff members entered Resident #9's room on five separate occasions throughout the observation and failed to ensure Resident #9's fall mat was in place on the floor next to her bed. -Three unidentified staff members walked by Resident #9's room while the door was open and failed to ensure Resident #9's fall mat was in place on the floor next to her bed. During a continuous observation on 6/2/25, beginning at 3:15 p.m. and ending at 4:00 p.m. Resident #9 was in her bed and the fall mat was not in place on the floor next to her bed. D. Record review Resident #9's fall care plan, revised 8/9/23, documented she was at moderate risk for falls and injury secondary to progressive MS with mobility and positioning deficits and seizure disorder. A Broda chair was used for positioning the resident and as her primary mode of mobility. Pertinent interventions included a fall mat (initiated 5/31/22). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9's seizure care plan, revised 5/31/22, documented she had a seizure disorder and potential for injury. Pertinent interventions included a high low bed and a fall mat (initiated 5/31/22). Resident #9's 5/8/25 fall assessment documented the resident was disoriented, at moderate risk for falls due to progressive multiple sclerosis with mobility and positioning deficits with seizure disorder and had three or more diagnoses that could contribute to falls. The assessment documented the resident had had one to two falls in the last 90 days. E. Staff interviews Licensed practical nurse (LPN) #1 and LPN #2 were interviewed together on 6/3/25 at 11:08 a.m. LPN #1 and LPN #2 said it was the responsibility of the CNAs to place the fall mat on the floor if they put Resident #9 back in bed. LPN #1 said the fall mat intervention was not in the resident's treatment administration record (TAR) and she was not sure if the facility still used the fall mat as an intervention for Resident #9. CNA #7 was interviewed on 6/3/25 at 11:15 a.m. CNA #7 said she looked at residents' care plans to see fall interventions. CNA #7 said she did not remember if Resident #9 used a fall mat but would check the care plan for interventions. The DON was interviewed on 6/3/25 at 6:00 p.m. The DON said Resident #9 could move slightly but she did not have purposeful movements. The DON said the fall mat intervention was more appropriate as a seizure activity intervention versus a fall intervention. The DON said if the fall mat was on the care plan as an intervention then the fall mat should have been used.Based on observations, record review and interviews, the facility failed to ensure three (#63, #9 and #133) of seven residents reviewed for accidents out of 35 sample residents received adequate supervision to decrease and/or prevent risk for accident hazards. Specifically, the facility failed to: -Ensure fall interventions were consistently implemented and reviewed for effectiveness for Resident #63 who sustained 14 falls in less than six months; -Ensure care planned fall and seizure activity interventions, specifically a fall mat, were implemented consistently for Resident #9; -Accurately assess Resident #133's initial elopement risk following the resident's elopement on 5/19/25; and, -Reassess Resident #133's elopement risk in order to identify appropriate and effective interventions to ensure the resident would be kept safe from elopement after he removed his wanderguard device on 6/2/25 and on 6/3/25 and refused to allow staff to put the device back on. Findings include: I. Facility policy and procedure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Neurological Assessments and Fall Follow-Up Documentation policy, reviewed 5/13/25, was provided by the nursing home administrator (NHA) on 6/3/25 at 5:20 p.m. It read in pertinent part, It is the policy of this facility that all residents who experience a fall with head involvement or a head injury without a fall receive a 72-hour neurological assessment and documented fall follow-up order to ensure proper monitoring and early detection of complications. All fall-related injuries must be assessed and addressed immediately, and fall interventions must be implemented immediately to reduce the risk of recurrence. Licensed nurses are responsible for conducting, documenting, and following up on all fall-related neurological assessments, interventions and pain monitoring. CNAs (certified nurse aide) and caregivers must report any resident changes, assist in implementing interventions, and monitor pain levels. II. Resident #63 A. Resident status Resident #63, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included history of falling, pain in his right hip and dementia. The 4/19/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required supervision assistance with transferring, toileting and personal hygiene. The MDS assessment indicated the resident had a history of two or more falls prior to admission B. Observations on 5/28/25 at 3:50 p.m. Resident #63 was in his room lying in his bed watching television. The resident's call light was on the resident's wheelchair at the foot of the resident's bed. Resident #63 was unable to reach his call light. The resident had socks on both of his feet that did not have anti-slip material on the bottom of them. No floor mat was noted next to his bed and his bed was not in the lowest position close to the floor. C. Resident interview Resident #63 was interviewed on 5/29/25 at 9:39 a.m. Resident #63 said he had fallen at the facility. Resident #63 said he did not think he needed help from the nursing staff. D. Record review Review of Resident #63's fall care plan, created on 6/17/24 and revised 1/29/25, revealed the resident was at risk for falls related to muscle weakness and dementia. Interventions included ensuring the resident's call light was within reach and encouraging the resident to use it (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for assistance as needed (initiated 6/17/24), promptly responding to all requests for assistance (initiated 6/17/24), anticipating and meeting the resident's needs (initiated 6/17/24), ensuring that the resident was wearing appropriate footwear (sneakers) when ambulating with a four-wheel walker (initiated 8/22/24), moving the resident to a room closer to the nurse's station to help prevent falls/injuries (initiated 12/30/24) providing staff education that the resident could not be left alone on the toilet (initiated 1/2/25) and providing the resident with standby assist to get to bed (initiated 1/2/25). -However, the care plan was not updated after each fall to reflect that the care planned fall interventions were reviewed for effectiveness or when a new intervention was put into place (see falls below). Review of Resident #63's electronic medical record (EMR) revealed the resident sustained the following falls from 12/10/24 to 5/13/25: 1. Fall incident on 12/10/24 - unwitnessed A nurse's note, dated 12/10/24 documented nursing staff heard the loud noise of residents screaming at each other and went to the activity area to check on them. Resident #63 was sitting on the floor. There was a slight redness to the skin on the back of the resident's neck without any open injuries. The residents were separated and the other resident was placed on one-to-one supervision. The other resident reported Resident #63 pushed the other resident's walker first and the other resident responded by pushing Resident #63 to the floor because he was not able to cope with Resident #63 touching his walker with anger first. The interdisciplinary team (IDT) review note, dated 12/16/24, revealed the IDT met and discussed the resident's 12/10/24 fall. The note indicated the new intervention for the resident was to have a referral to behavioral health services (BHS) for evaluation and treatment of the resident's angry outbursts. -However, the IDT's review of the fall was not completed until six days after the fall and after Resident #63 had sustained another fall on 12/14/24 (see below). 2. Fall incident on 12/14/24 - witnessed A nurse's note, dated 12/14/24 documented that the activities assistant called the facility and reported Resident #63 fell while on a facility shopping outing after feeling weak and wobbly in the knees. Resident #63 fell on his right hip and elbow. The resident stated he was in severe pain and the activities assistant did not feel comfortable helping him up. An ambulance was called and the resident was taken to the hospital for further assessment. The fall resulted in a right hip fracture for Resident #63. A nurse's note, dated 12/19/24, documented Resident #63 was readmitted to the facility from the hospital. The resident was reoriented to his room and his call light. The resident's bed was in the lowest position and all of his personal belongings were within reach. His vital signs were stable and he was reporting pain of 6 out of 10 on a 1-10 pain scale in his right hip. The resident was unable to bear any weight to bilateral lower extremities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, there was no documentation to indicate additional fall interventions were put into place due to the resident's new inability to bear weight on his lower extremities. -Additionally, there was no documentation in Resident #63's EMR to indicate the IDT had reviewed the resident's 12/14/24 fall to determine the effectiveness of the resident's care planned fall interventions or to determine if there was a need for additional interventions. 3. Fall incident on 12/19/24 - unwitnessed A nurse's note, dated 12/19/24, documented that at approximately 9:20 p.m. staff were notified by Resident #63's roommate that the resident was on the floor. The nurses found Resident #63 lying in a supine position (lying face upward) on the floor, parallel to his bed. The resident reported he was trying to get into his recliner and was unable to stand up and fell to the floor. Neurological assessments were initiated per protocol and were within normal limits. Three staff members used a mechanical lift to assist the resident back to bed and he was assisted with raising the head of his bed to sit up in bed rather than being in his recliner, as he was attempting to do when he fell. The resident was satisfied with the option. Fluids, call light and personal items were all placed at the resident's bedside within reach. Resident #63 denied new/worsening pain. The physician and the resident's representative were notified. An IDT note, dated 12/20/24, documented the IDT met and discussed the 12/19/24fall. The root cause of the fall was determined to be Resident #63's new impulsivity and not using his call light for help. Interventions included moving the resident to a room closer to the nurses' station. 4. Fall incident on 12/20/24 - unwitnessed A nurse's note, dated 12/20/24, documented Resident #63 was observed lying on the floor next to his bed. There was bruising from his previous fall noted to his right thigh. The resident was assisted to bed with three staff members and a mechanical lift. He was moaning with pain to his right hip. There were no new skin injuries noted. -There was no documentation in Resident #63's EMR to indicate the IDT had reviewed the resident's 12/20/24 fall to determine the effectiveness of the resident's care planned fall interventions or to determine if there was a need for additional interventions. 5. Fall incident on 12/25/24 - unwitnessed A nurse's note, dated 12/25/24 documented Resident #63 had an unwitnessed fall at around 10:00 a.m. A certified nurse aide (CNA) reported Resident #63 was found lying on his back on the floor. The resident said he was trying to grab his walker to go to the bathroom but he slid off the bed. The resident was assessed and no new injuries were noted. The resident denied hitting/bumping his head during the fall. Resident #63 was helped to his bed with assistance from two staff members and education was provided to always call using his call light for assistance. The resident was reminded to utilize his urinal that was present at his bedside. The resident's bed was placed in the lowest position and a floor mat was in-place. Frequent checks were maintained to ensure the resident's needs were met due to some mild confusion noted. Neurological assessments and vital signs were initiated and the physician and the resident's representative were notified. (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 documentation in Resident #63's EMR to indicate the IDT had reviewed the resident's 12/25/24 fall to determine the effectiveness of the resident's care planned fall interventions or to determine if there was a need for additional interventions. 6. Fall incident on 12/27/24 - unwitnessed A nurse's note, dated 12/27/24, documented nursing staff was alerted to come to Resident #63's bathroom as he had an unwitnessed fall. The resident had attempted to stand up from the toilet without calling for assistance. The resident was sitting next to the toilet when the nurse arrived, his range of motion (ROM) was at baseline, he denied hitting his head, there were no red marks or bumps on his head and no abrasions or redness to his back.The resident had bruises that were fading from his previous falls and he had weakness from not walking because of his previous falls. Resident #63 was assisted to a standing position with assistance from a CNA, put back in bed, neurological checks were initiated and the physician was notified. An IDT note, dated 12/30/24 documented the IDT met and discussed the 12/27/24 fall. The new intervention was to educate staff that the resident could not be left on the toilet alone because he would attempt to walk back to bed without assistance and he was unable to walk alone at that time. -However, the intervention to not leave the resident unattended on the toilet was not updated on the care plan to alert staff of the new intervention. 7. Fall incident on 1/17/25 - unwitnessed A nurse's note, dated 1/17/25, documented Resident #63 was sitting on the floor on his fall mat. There was no skin injury noted and the resident was able to move all of his extremities without pain or change in ROM. He was confused and when asked how he got to the floor, he did not respond. The resident's bed was placed in the lowest position at this time. The physician and the nurse on-call were notified of the fall. -There was no documentation in Resident #63's EMR to indicate the IDT had reviewed the resident's 1/17/25 fall to determine the effectiveness of the resident's care planned fall interventions or to determine if there was a need for additional interventions. 8. Three fall incidents on 1/20/25 (eighth, ninth and tenth falls) - unwitnessed A nurse's note, dated 1/20/25 at 9:11 a.m., documented Resident #63 had three unwitnessed falls that morning at 6:40 am and 8:30 am. The note documented a CNA found the resident sitting on his floor mat. This nurse went to the resident's room and found him in a sitting position with both of his legs folded and a smile on his face. The resident was confused and unable to say how he fell. The resident's bed was in the lowest position and his call light was within reach during the incident. The nurse assessed the resident for any injuries and no injuries were noted. The resident was educated to call for help or press the call light. The physician, the resident's representative and the director of nursing (DON) were notified. -The progress note referenced three falls, however the progress note only documented the times for two of the falls and there were no additional progress notes documented for the 6:40 a.m. fall or the 8:30 a.m. fall referenced in the note. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 1/20/25, documented Resident #63 was to be sent to the hospital for increased falls/confusion and agitation. The resident had appeared confused for a few days and he appeared to be more aggressive and agitated with confusion. He had a fall times three today (1/20/25). The physician was aware and provided an order to send him to the hospital for further evaluation. A pharmacy medication review note, dated 1/23/25, documented medications that may have contributed to Resident #63's fall on 1/20/25 or may increase risk of future falls included methocarbamol (muscle relaxant) , oxycodone (pain medication). Other medications included the resident's antihypertensive medications and antidiabetic medication, however the pharmacist indicated those medications did not seem likely considering the circumstances of the resident's fall. The pharmacist's recommendations, based upon the resident's increased frequency of falls and description of the resident being confused, were to reduce the dose of the resident's oxycodone and/or the methocarbamol to reduce confusion, especially if the resident's pain was controlled. A nurse's note, dated 1/24/25, documented Resident #63 was readmitted to the facility from the hospital with a diagnosis of a urinary tract infection(UTI). The resident's mental status was super confused. -However, there was no documentation to indicate additional fall interventions were put into place due to the resident's new diagnosis of a UTI and his increased confusion. -Additionally, there was no documentation in Resident #63's EMR to indicate the IDT had reviewed the resident's three falls on 1/20/25 to determine the effectiveness of the resident's care planned fall interventions or to determine if there was a need for additional interventions. 9. Fall incident on 1/29/25 - unwitnessed A nurse's note, dated 1/29/25, documented nursing staff heard a loud thump from Resident #63's room. Staff rushed into the resident's room and found the resident lying on the floor on his right side. The resident was reporting pain to his left hip. The resident was assisted off the floor and back into his recliner chair. His neurological status was at baseline and the physician, the resident's representative and the DON were notified. The physician gave an order to obtain a pelvic Xray. A therapy note, dated 1/30/25, documented Resident #63 fell while attempting to sit in his wheelchair without locking the brakes first. Therapy would be installing an anti-rollback device this date in order to decrease the resident's fall risk and the resident would continue with therapy services. An IDT note, dated 1/30/25 documented the IDT had reviewed #63's 1/29/25 fall. The IDT implemented a new intervention to apply anti-rollback devices to the resident's wheelchair. -However, the intervention for the anti-rollback devices was not updated on the care plan to alert staff of the new intervention. 10. Fall incident on 3/12/25 - unwitnessed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note, dated 3/12/25, documented nursing staff found Resident #63 on the floor in his bathroom sitting upright. He was not a good historian and was unable to give an account of how he got on the floor. A head to toe assessment was completed and the resident had no noted physical injury. Resident #63 was helped back to his feet and back to bed. The physician, the resident's representative and the on-call nurse were notified. A therapy note, dated 3/12/25, documented Resident #63 was participating in physical therapy (PT) for fall prevention, functional strength training and to return the resident to his prior level of functioning. The resident was actively participating and making progress towards the established therapy goals. The resident was currently on a toileting program every two hours from 8:00 a.m. to 8:00 p.m., as was recommended by occupational therapy (OT). The note indicated the IDT had added a toileting schedule for the middle of the night in order to decrease the resident's risk for falling in the bathroom again. -However, the intervention for the toileting program was not updated on the care plan to alert staff of the new intervention. -Additionally, there was no documentation in the resident's EMR to indicate staff was following the toileting program schedule for Resident #63. 11. Fall incident on 4/30/25 - unwitnessed A nurse's note, dated 4/30/25, documented Resident #63 had a small amount of blood on the top of his head. The resident said he did not fall, but he bumped his head on the dresser. The area to the right side top of his head was cleansed with wound cleanser and left open to air. Neurological checks were started. The resident had no complaints of pain/discomfort. The physician, the resident's representative, the DON and the on-call nurse were notified. An IDT note, dated 5/1/25, documented the IDT had reviewed Resident #63's 4/30/25 fall. The resident was offered padding for his dresser, however, he declined to allow staff to put any padding on his furniture. The resident said he would be more careful when putting clothes away in his room. 12. Fall incident on 5/13/25 - unwitnessed A nurse's note, dated 5/13/25, documented Resident #63 had an unwitnessed fall. Resident #63 reported he was getting in his chair and the dresser moved. An assessment was completed and there was no injury noted. Neurological checks and ROM were within normal limits for the resident. The resident had no complaints of pain/discomfort. The physician and the resident's representative were notified. Staff offered to move the furniture in the room but the resident declined. The resident's dresser was being secured to the floor to prevent it from moving when the resident transferred. -There was no documentation in Resident #63's [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#184) of two residents who required respiratory care received care consistent with professional standards of practice out of 35 sample residents. Specifically, the facility failed to ensure oxygen was administered as ordered by the physician for Resident #184. Findings include: I. Facility policy and procedure The Respiratory Care and Oxygen Administration policy and procedure, revised 5/13/25, was provided by the nursing home administrator (NHA) on 6/3/25 at 5:22 p.m. It read in pertinent part, The facility provides respiratory care, including the administration of oxygen, in accordance with medical orders and based on residents' clinical needs. Care shall be safe and evidence-based. Procedures, including respiratory care, must be ordered by a physician, nurse practitioner, or physician's assistant. Nursing staff will assess residents for signs of respiratory distress upon admission and routinely thereafter. Respiratory orders must specify oxygen flow rate, delivery method and frequency. Verify the physician's order prior to administration. Observe respiratory rate, oxygen saturation, breath sounds, and effort at least every shift. II. Resident #184 A. Resident status Resident #184, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included cardiac arrest (when the heart stops beating suddenly), acute respiratory failure with hypoxia, anoxic brain damage (when the brain is deprived of oxygen for a period, leading to damage or death of brain cells), cerebrovascular disease, dependence on supplementary oxygen and seizures. The 4/15/25 minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS) assessment. According to the staff assessment for mental status, the resident had short-term and long-term memory deficits, severely impaired decision making and continuous disorganized thinking. Resident #184 was not cognitively oriented to staff names and faces. He was dependent on staff for all of his activities of daily living (ADLs). According to the MDS assessment, the resident had a debilitating cardiorespiratory condition and respiratory failure. The MDS assessment identified the resident required oxygen therapy, suctioning and tracheostomy care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 5/28/25 at 2:14 p.m. Resident #184 was lying in bed. Resident #184 had a tracheostomy inserted through the center of his throat, with oxygen running through the tracheostomy. His oxygen concentrator was turned on and set at approximately 4.8 liters per minute (LPM) of oxygen. Resident #184 was partially awake and was taking deep breaths. The resident would open his eyes momentarily, take a deep breath, and close his eyes. On 5/29/25 at approximately 9:44 a.m. Resident #184 was in bed, lying flat with his face pointed up toward the ceiling. His tracheostomy was attached to his trachea with an oxygen tube connected to the tracheostomy. His oxygen concentrator was set at 4.8 LPM of oxygen. On 6/2/25 at approximately 11:40 a.m. registered nurse (RN) #1 entered Resident #184's room to set up a formula for the resident's tube feeding. RN #1 donned (put on) a protective gown and gloves. RN #1 performed tracheostomy care, administered medications via the resident's gastrostomy tube, checked the resident's pulse oximetry and then left the resident's room after disposing of the gown and gloves. -RN #1 failed to check the liter flow of oxygen for Resident #184 or identify that the resident was receiving 4. 8 LPM of oxygen instead of the continuous 4 LPM of oxygen that was specified by the resident's physician's order for oxygen (see physician's order below). C. Record review A review of Resident #184's May 2025 CPO revealed the following physician's order: Resident on 4 LPM of oxygen via trach (tracheostomy) every shift for shortness of breath (SOB), ordered 3/6/25. Further review of the resident's physician order history revealed Resident #184 had a physician's order for 6 LPM of oxygen via tracheostomy that was discontinued on 3/6/25. The oxygen care plan, revised 1/29/25, revealed Resident #184 received oxygen therapy related to respiratory failure with hypoxia. -The care plan did not include that Resident #184 required oxygen at 4 LPM via tracheostomy. The May 2025 oxygen saturation log, between 5/1/25 and 5/31/25, documented Resident #184's oxygen saturation levels (level of oxygen in the blood) were checked two to three times a day and ranged between 91 percent (%) and 97%. D. Staff interviews (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed on 6/2/25 at 11:46 a.m. RN #1 said Resident #184 had a physician's order for 4 LPM of oxygen via tracheostomy. RN #1 confirmed the resident was receiving 4.8 LPM of oxygen instead of 4 LPM. RN #1 said she did not know why the resident' oxygen concentrator was set to 4.8 LPM. RN #1 said she did not check the resident's oxygen settings at the start of her shift and she was not aware that Resident #184 was receiving more oxygen than the physician's order specified he should receive. She said only nurses were allowed to adjust oxygen settings on the concentrators. RN #1 said there was no titration order (order that includes a target oxygen saturation level and instructions for gradually adjusting the oxygen flow rate to maintain that oxygen saturation level target) with the resident's order and the concentrator should be left at 4 LPM. RN #1 said Resident #184 was not physically able to adjust the oxygen setting himself. Licensed practical nurse (LPN) #3 was interviewed on 6/2/25 at 2:05 p.m. LPN #3 said Resident #184 had a physician's order for 4 LPM of oxygen via tracheostomy with no titration order. LPN #3 said oxygen was a medication and required a physician's order to initiate oxygen therapy. LPN #3 said a physician's order for the use of oxygen should be followed to avoid complications associated with high levels of oxygen in the blood. The director of nursing (DON) and the NHA were interviewed together on 6/3/25 at 12:45 p.m. The DON said all nursing staff were responsible for ensuring that oxygen was administered according to the physician's orders. The DON said only nurses were permitted to set, titrate and initiate oxygen therapy. The DON said nurses should check the settings of each residents' oxygen concentrator at least once every shift. The NHA said a physician's order for oxygen should include the diagnosis explaining the reason oxygen was needed, the flow rate for the oxygen, duration of use and the delivery method for the oxygen. The NHA said nursing staff would be re-educated immediately on the need to ensure oxygen orders were followed. E. Facility follow-up On 6/4/25 at 2:15 p.m., following the survey exit, the NHA provided the following information via email: The NHA's email revealed the facility's respiratory therapist (RT) was consulted to reassess the appropriateness of Resident #184's existing oxygen order. According to the NHA, the facility's RT concluded that, based on Resident #184's chronic tracheostomy and fluctuating respiratory status, a titrated oxygen range order was more clinically appropriate for the resident than a continuous fixed flow rate of oxygen. The information submitted by the NHA revealed Resident #184's physician's order for 4 liters LPM of oxygen was discontinued on 6/4/25 at 1:15 p.m. and the following physician's order was obtained: -Oxygen delivery via tracheostomy cannula: administer oxygen via a humidified tracheostomy. Flow rate range: 4 LPM to 10 LPM, maintain oxygen saturation between 88% and 100% every shift for altered respiratory status. If SpO2 (oxygen saturation level) falls below 88%, increase flow by 1 LPM every 5 (five) minutes up to a maximum of 10 LPM. Notify the physician if oxygen requirement exceeds 10 LPM or if signs of respiratory distress are observed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#55) of six residents reviewed for medications errors out of 35 sample residents. Specifically the facility failed to ensure Resident #55 was administered Percocet (pain medication) per physician's orders. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Resident #55 A. Resident status Resident #55, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included acute myocardial infarction (heart attack), chronic obstructive pulmonary disease (lung disease), acute and chronic respiratory failure, fractured thoracic vertebra (12 bones of the vertebrae), heart failure and chronic respiratory failure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/22/25 minimum data set assessment (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial assistance bathing, moderate assistance with dressing and hygiene, and set-up assistance for meals. The assessment documented the resident was on a scheduled pain medication regimen, received as needed pain medication and received non-medication intervention for pain. The assessment revealed the resident frequently had pain that frequently affected her sleep and day-to-day activities and pain intensity was seven out of 10. B. Resident interview Resident #55 was interviewed on 5/28/25 at 11:00 a.m. Resident #55 said she did not feel like the facility effectively managed her pain and her pain medication needed to be adjusted. III. Record review Resident #55's pain care plan, revised 12/18/24, documented she was at risk for pain due to diagnoses of heart failure, history of myocardial infarction, chronic obstructive pulmonary disease,and a history of fractured thoracic vertebra, muscle spasms, and chronic kidney disease. Pertinent interventions, initiated 10/2/24, included to anticipate the resident's need for pain relief and respond immediately to any complaint of pain, to identify and record previous pain history and management of that pain and impact on function, to monitor/document for probable cause of each pain episode and remove/limit causes where possible and to notify the physician if interventions are unsuccessful or if current complaint was a significant change from residents past experience of pain. The resident's pain medication care plan, revised 8/17/24, documented the resident was on pain medication therapy due to back pain. Pertinent interventions included to administer analgesic medications as ordered by the physician and monitor and document the side effects every shift, asking the physician to review medication if the side effects persist and assessing whether the pain intensity was acceptable to the resident The resident's care plan documented she had a history of fracture to her thoracic vertebrae and diagnosis. She was at risk for pain, fracture, and falls, and generalized weakness, revised 10/10/24. Pertinent interventions included to give pain and anti-inflammatory medications as ordered and monitor the side effects and handle gently when moving or positioning. A review of Resident #55's May 2025 CPO revealed the resident had physician's orders for the following medications: -Oxycodone 5 milligrams (mg) by mouth, one tablet by mouth every 12 hours as needed for pain management, ordered 5/13/25. -Percocet 325 milligrams (mg) by mouth three times a day for chronic pain, ordered 5/13/25. Resident #55's May 2025 Medication administration record (MAR) revealed the resident did not receive her percocet as ordered for two of two opportunities on 5/15/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/15/25 nurses progress note documented at 1:47 a.m. the resident was being monitored for a decrease in oxycodone and added Percocet. The resident stated that the change in medication was not helping and that she wanted it switched back. A 5/15/25 administration note documented at 12:15 the Percocet was on order and not administered to the resident. A 5/15/25 administration note documented at 12:16 p.m. Resident #55 requested oxycodone for pain level of 8 out of 10. A 5/15/25 administration note documented at 4:45 p.m. the Percocet was on order and not administered to the resident. A 5/15/25 administration note documented at 4:52 p.m. the oxycodone pain administration was ineffective and the follow-up pain scale was an 8 out of 10. A 5/15/25 administration note documented at 6:15 p.m. revealed the resident was on follow-up monitoring for a decrease in dosage of oxycodone and addition of Percocet. The resident reported she was never notified of the change in dosage and addition of percocet. -However, there were no progress note documented to indicate the resident's physician had been notified Resident #55's pain medication was not available and not administered to the resident, and the resident's medication was ineffective in treating her pain. IV. Staff interviews The director of nursing (DON) was interviewed on 6/3/25 at 1:10 p.m. The DON said Resident #55 was previously on scheduled oxycodone that had been changed to as needed on 5/13/25 and scheduled Percocet was added. The DON said on 5/15/25 the Percocet was prescribed and nothing else was given to the resident except the as needed oxycodone. The DON said the nurse should notify the physician if a medication was not available to administer. The DON said the pharmacy could tell the facility when a medication was being delivered to the facility. The DON said the Percocet was an added prescription and not a change in the order. The DON said if the facility did not have the Percocet the nurses could pull something from the ekit (a medical supply kit). The DON said the nurse should have called and notified the physician the medication was not available

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Ensure housekeeping staff followed appropriate infection control guidelines when cleaning residents' bathrooms; -Ensure housekeeping staff applied alcohol-based hand sanitizer per guidelines when cleaning residents' rooms; -Ensure staff donned appropriate personal protective equipment (PPE) when providing direct care for Resident #45, who was on enhanced barrier precautions (EBP); and, -Ensure staff donned appropriate PPE when providing wound care for Resident #16, who was on EBP. Findings include: I. Housekeeping failures A. Professional reference The Centers for Disease Control and Prevention's (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 6/5/25 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/pre ent/resource-limited/cleaning-procedures. html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. According to the CDC's Hand Sanitizer Guidelines and Recommendations (3/12/24), retrieved from https://www.cdc.gov/clean-hands/about/hand-sanitizer.html#:~:text=Apply%20the%20gel%20product%20to, should%20take%20around%2020%20seconds., on 6/10/25, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you. Apply the gel product to the palm of one hand; Cover all surfaces of hands; and, Rub your hands and fingers together until they are dry. This should take around 20 seconds. Don't rinse or wipe off the hand sanitizer before it's dry; it may not work well against germs. B. Facility policy and procedure The Housekeeping and Environmental Cleanliness policy, revised 11/13/24, was provided by the nursing home administrator (NHA) on 5/29/25 at 10:33 a.m. It read in pertinent part, To ensure that the facility is maintained in a clean, sanitary, and orderly condition to promote resident safety and comfort. Resident rooms are cleaned daily and as needed, and bathrooms disinfected with approved products. All housekeeping staff are trained upon hire and annually in infection control practices, safe chemical handling and proper cleaning techniques. C. Observations During a continuous observation on 6/3/25 at 8:50 a.m., housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER] and room [ROOM NUMBER]. HK #1 pushed the cleaning cart to the entrance of room [ROOM NUMBER]. She opened the cart and donned (put on gloves), entered the room and emptied two trash cans. She returned to the cart, removed her gloves, applied alcohol-based hand sanitizer and immediately donned a pair of gloves. She struggled to put on the gloves due to her hands being visibly wet with the alcohol-based hand sanitizer. HK #1 entered room [ROOM NUMBER] again and cleaned the high-touch areas, including the door knobs, bed controller, call light, and bedside table. She returned to her cart, removed a blue rag and disinfectant solution from the cart and entered the resident's bathroom. HK #1 sprayed a blue disinfectant solution onto the bathroom sink and cleaned the bathroom mirror. She used the blue rag to clean the mirror and the sink. HK #1 returned to the cleaning cart and placed the disinfectant solution on the cart. She removed her gloves, applied alcohol-based hand sanitizer and immediately applied clean gloves without allowing her hands to dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #1 returned to room [ROOM NUMBER]'s bathroom with the blue disinfectant solution and a scrubbing brush. She sprayed the toilet with the disinfectant solution and allowed it to sit for approximately one minute. She used the blue rag to wipe the seat of the toilet, the rim of the toilet and around the toilet bowl. She wiped the side of the toilet again,the side of the toilet tank, the front of the toilet tank and the top of the toilet tank with the same blue rag. She sprayed the grab bar on the right side of the toilet wall with the disinfectant solution and wiped it with the same blue rag. HK #1 swept and mopped the floor in room [ROOM NUMBER] before pushing the cleaning cart to the entrance of room [ROOM NUMBER]. -HK #1 did not rub her hands with the hand sanitizer until they were dry before applying gloves. -HK #1 failed to clean the bathroom from a cleaner area to a dirtier area HK #1 used hand sanitizer, immediately donned gloves without allowing the hand sanitizer to dry and entered room [ROOM NUMBER]. She emptied two trash cans and proceeded to the cleaning cart to discard the trash from the resident's room. She took off her gloves, applied hand sanitizer, and immediately donned new gloves, again without rubbing her hands until the hand sanitizer was dry. She removed the container of disinfectant solution and a blue rag from her cart and washed the inside of the sink, the mirror and the surface of the sink in the resident's bathroom. She returned the container to the cart. HK #1 removed a toilet brush, a new blue rag and the disinfectant solution spray from the cleaning cart and proceeded to room [ROOM NUMBER]'s bathroom. The toilet seat had splashes of urine on the surface. She sprayed the disinfectant solution onto the surface of the toilet seat and the inside of the toilet bowl and scrubbed it with the toilet brush. She placed the toilet brush into the brush holder, which she placed on the dirty floor beside the toilet bowl. HK #1 picked up the scrubbing brush holder from the floor and placed it on the cleaned surface of the bathroom sink. HK #1 then sprayed the toilet with the disinfectant solution spray bottle and used the blue rag to wipe the toilet seat, the rim of the toilet, the back of the toilet, both sides of the toilet, the top of the toilet tank, around the toilet tank and finished by wiping the toilet seat again. -HK #1 failed to clean the bathroom from cleaner to dirtier areas to avoid spreading dirt and microorganisms. -HK #1 failed to avoid contaminating clean surfaces by placing a dirty toilet brush container on the cleaned sink surface. -HK #1 did not rub her hands with hand sanitizer until they were dry before applying gloves. D. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #1 was interviewed on 6/3/25 at 9:22 a.m. HK #1 said she found it difficult to don gloves because her hands were wet with the hand sanitizer. She said it would have been easier to apply gloves if she had allowed her hands to dry before applying gloves. She said hand sanitizers were less effective if not used properly. She said she should not have placed the scrubbing brush from the toilet on the cleaned surface of the sink in the bathroom to prevent cross-contamination of microorganisms. She said the residents' toilets should have been cleaned from top to bottom. She said she forgot not to use the same cleaning rag for the toilet and the grab bar in the room [ROOM NUMBER]'s bathroom. The housekeeping supervisor (HKS) was interviewed on 6/3/25 at 9:30 a.m. The HKS said the toilet brush should never be placed on any clean surface after using it to clean the toilet. She said the toilet should be cleaned with a clean rag from top to bottom. She said HK #1 should not have used the same rag to clean the toilet and the grab bar in room [ROOM NUMBER]'s bathroom. The HKS said HK #1 should have allowed her hands to dry before applying gloves for the hand sanitizer to be effective She said she would immediately re-educate HK #1 and all housekeeping staff on proper cleaning procedures. II. EBP failures A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) (4/2/24), retrieved on 6/4/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, EBP are an infection control intervention, designed to reduce transmission of resistant organisms, that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Infection Control policy, revised 11/13/24, was provided by the NHA on 5/29/25 at 10:33 a.m. It read in pertinent part, Enhanced barrier precautions are used for residents with wounds, indwelling devices such as catheters, tracheostomies or those at high risk of multidrug-resistant organisms (MDROs) colonization, even if they are not known to be infected. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Used for residents in high-risk categories in nursing homes, especially during MDRO outbreaks or colonization events, requirements include gloves and gowns during high-contact resident care activities such as dressing, bathing, toileting and device care. Enhanced signage and personal protective equipment (PPE) in the resident care area, staff education and competency validation on all isolation practices, monitoring and auditing compliance through direct observation. All staff are trained and regularly audited to ensure adherence to these guidelines and to protect the health and safety of all individuals in the facility. C. Resident #45 1. Observations On 5/29/25 at 1:40 p.m. Resident #45 was lying in bed. He turned his call light on and certified nurse aide (CNA) #2 responded to the resident's call light. CNA #2 entered the resident's room and asked the resident what she could do to assist him. Resident #45 asked to be repositioned in bed. CNA #2 removed both of the resident's feet from his pressure injury boots (bunny boots) and held the resident's legs and feet to adjust them. Resident #45 had a diabetic wound on his right second toe, a diabetic foot ulcer with wounds to his left heel and wounds on his sacrum (buttocks). CNA #2 held Resident #45's feet without gloves, applied the bunny boots to the resident's feet and repositioned the resident using a wedge cushion. -CNA #2 failed to put on gloves or a gown before assisting Resident #45, who had wounds which required the use of EBP, to reposition. On 6/2/25 at 11:25 a.m., a restorative nurse aide (RNA) #6 arrived at Resident #45's bedroom to provide range of motion (ROM) exercises in the resident's bed. RNA #6 applied gloves but did not don a protective gown. He touched the resident's right hand and aligned it with his hands to provide ROM. RNA #6 removed the bunny boots from the resident's feet and held the resident's feet from below the heel area with his left hand. RNA #6 began providing ROM to Resident #45's feet. RNA #6 held the resident's feet close to the area of his diabetic wounds while providing ROM. -RNA #6 failed to put on a protective gown before providing ROM to Resident #45. On 6/2/25 at approximately 1:15 p.m. CNA #1 responded to Resident #45's call light and the resident requested to be changed. CNA #45 applied gloves, lifted the resident's bed and removed the resident's bed linens and started changing the resident. -CNA #1 failed to don a protective gown while changing Resident #45. D. Resident #16 1. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/25 at 11:22 a.m. a sign on Resident #16's door indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. Gloves and blue gowns were observed in Resident #16's room in clear plastic bins. On 5/29/25 at 11:24 a.m. licensed practical nurse (LPN) #1 was completing wound care with a dressing change for Resident #16, who had a pressure wound on her sacral area. The wound was observed in the sacral area with clear, yellow tinged drainage. LPN #1 had gloves on. -However, LPN #1 failed to put on a gown prior to performing wound care with the resident. 2. Resident interview Resident #16 was interviewed on 5/29/25 at 11:30 a.m.Resident #16 said when the nurses were changing her wound dressing, the nurses would put on gloves but they never wore a gown. E. Staff interviews LPN #1 was interviewed on 5/29/25 11:38 a.m. LPN #1 said Resident #16 was on EBP because the resident had an indwelling foley catheter foley and colostomy. LPN #1 said she never wore a gown for Resident #16 when she completed her wound dressing changes. LPN #1 said she was now aware of the requirement to wear a gown with wound dressing changes. LPN #1 said now that she knew the correct PPE to don, she would make sure she always wore a gown and gloves with wound care in the future. CNA #6 was interviewed on 5/29/25 at 12:35 p.m. CNA #6 said when she was providing care for any resident on EBP, she would don gloves and a gown. CNA #6 said if she was going to assist the resident with transfers, using the bathroom or helping the nurse with colostomy care, she would put on a gown and gloves to ensure the resident would not get an infection. CNA #6 said she was provided education and instruction on PPE by the facility. RN #3 was interviewed on 6/2/25 at 11:22 a.m. RN #3 said whenever she provided Resident #16 with wound care, cleaning or emptying her foley catheter or changing the resident's colostomy bag, she would wear gloves and a gown because that was the facility's protocol. RN #3 said the EBP was in place to prevent Resident #16 from getting an infection. She said all nursing staff should wear gloves and a gown with high contact care such as transfers, providing incontinence care and wound care. CNA #2 was interviewed on 6/2/25 at 1:45 p.m. CNA #2 said she did not know she had to put on a protective gown when providing care for Resident #45. CNA #2 said the only time that she applied PPE was when there was an isolation cart in front of the resident's room. She said she had received training on all isolation precautions, but she did not know to wear gloves and a protective gown before repositioning Resident #45. She said the sign posted in front of Resident #45's room should have reminded her to follow the procedure for EBP. Registered nurse (RN) #1 was interviewed on 6/2/25 at 1:55 p.m. RN #1 said there were signs posted at the entrance of each resident's room who was on EBP. She said PPE should be worn when performing personal care as indicated on the resident's care plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 6/3/25 at 12:45 p.m. The DON said residents on EBP had signage posted at the entrance of their rooms and also indicated on their care plans. She said EBP required the use of gloves, a protective gown and in some cases a face shield, depending on the task being performed. The DON said all nursing staff were trained on isolation precautions and should know to put on the proper PPE before performing any personal care to avoid the spread of infections. The DON said she did not know why the staff failed to follow the proper infection control procedures. She said she would ensure all nursing staff were re-educated on isolation procedures, including EBP. The NHA and the DON were interviewed together on 6/3/25 at 4:02 p.m. The NHA said the facility nursing staff were provided education and training on correct EBP policy and procedure from the DON. The DON said she provided education to staff upon hire and annually thereafter, on how and when to properly use PPE when a resident was on EBP. The DON said EBP was used for high-contact interaction between staff and residents. The DON said a resident would be placed on EBP if they had an ostomy (surgical incision in the abdomen), wounds or a foley catheter. The DON said the staff should wear PPE, including a gown and gloves, when assisting residents who were on EBP with activities of daily living (ADL). The NHA said she would have the DON provide re-education to staff on proper EBP protocol.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide adequate outside ventilation by means of windows and/or mechanical ventilation for one of two shower rooms and nine of 16 resident bathrooms. Specifically, the facility failed to ensure the exhaust fans in the north shower room and nine resident rooms were working properly. Findings include: I. Facility policy and procedure The Ventilation and Environmental Condition policy, revised 11/13/24, was provided by the nursing home administrator (NHA) on 6/3/25 at 5:22 p.m. It read in pertinent part, This facility shall maintain ventilation, lighting, and indoor environmental conditions that are safe, functional, and comfortable for residents, staff, and visitors. This policy applies to all maintenance and environmental services personnel responsible for managing heating, ventilation and air conditioning (HVAC), lighting and general facility comfort. Ventilation system requirements include operating HVAC systems in accordance with manufacturer instructions and American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards, ensuring that airflow does not compromise infection control and maintaining adequate natural and mechanical ventilation in all resident-use areas. II. Observations An observation of the residents' environment was completed with the maintenance director (MTD) on 6/3/25 at 10:40 a.m. There were exhaust fans installed in the ceiling of each resident's bathroom and the two main shower rooms (north and south shower rooms). The exhaust fan in the north shower room was not working and it was dirty with lint hanging from the surface of the vent. The exhaust fans in the bathrooms of room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] did not generate air movement with the switch turned on. As a measure of checking the function of each exhaust fan, a small square of single-ply toilet paper was placed against the vent. The exhaust fans were unable to hold the toilet tissue in place, which indicated the fans were not functioning at that moment. The vents in the bathrooms of room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] had large holes around the vents, exposing the electrical wires. The bathroom exhaust fans of room [ROOM NUMBER] and room [ROOM NUMBER] were missing. III. Staff interviews (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 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance director (MTD) was interviewed on 6/3/25 at 11:40 a.m. The MTD said the exhaust fan vents in the facility were old and needed to be replaced. He said monitoring was completed once a month for all the facility's exhaust fans. He said he repaired the fans that were broken but he said he had not come across the missing exhaust fans in room [ROOM NUMBER] and room [ROOM NUMBER] during his monitoring. The MTD said he did not know how and why the exhaust fans were missing from some of the bathrooms. He said the dirty vents would be cleaned immediately and new exhaust fans would be ordered to replace the missing ones. The NHA was interviewed on 6/3/25 at 1:08 p.m. The NHA said the proper functioning of the exhaust fan vents in the facility was important to promote air quality in the building. She said the maintenance monitoring form should be updated to include more specific checks of the ventilation system. She said orders had been placed for new vents and they would be installed as soon as they arrived. The NHA said she would reeducate the MTD and the maintenance staff on the importance of the ventilation system.