STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A185	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Colorado Hospital Ltc	373 E 10th Ave Springfield, CO 81073

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to ensure the resident's right to receive services in the facility with reasonable accommodation of the resident's needs and preferences for two (#20 and #13) of five residents reviewed for accommodation of needs out of 22 sample residents. Specifically, the facility failed to ensure Resident #20 and Resident #13 were able to self-adjust the water coming out of the faucets in their room sinks to a safe and comfortable temperature for their personal use when completing activities of daily living (ADL), including hand hygiene and grooming tasks. Findings include: I. Professional reference According to the National Institute of Health (NIH) Examining the Impact of Familiarity On Faucet Usability For Older Adults With Dementia, retrieved on 12/2/24 from https://pmc.ncbi.nlm.nih.gov/articles/PMC3716871/, A person's ability to complete ADLs is not only necessary for physical well-being, but is central to one's independence, pride, and dignity. A person who is unable to use products cannot autonomously complete associated activities, resulting in increased dependence on a caregiver and potential move to assisted living facilities. Better product usability could, in turn, potentially support independence and autonomy. More familiar faucets correlate with lower levels of assistance from a caregiver, fewer operational errors, and greater levels of operator satisfaction. Aspects such as the ability to control water temperature and flow, as well as pleasing aesthetics, appears to positively impact participants' acceptance of a faucet. The dual lever design achieved the best overall usability. II. Facility policy and procedure A policy for reasonable accommodations was requested on 11/21/24 at 4:59 p.m., however, the facility did not provide the requested policy. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #20 A. Resident status Resident #20, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included history of stroke, hypertension and anemia. The 10/7/24 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. The resident was independent with self-care tasks, such as personal hygiene, oral hygiene, toileting and dressing. B. Resident interview Resident #20 was interviewed on 11/19/24 at 10:30 a.m. Resident #20 said she did not like the automatic faucet in her room because she could never get the temperature right when she was washing up. Resident #20 said it was particularly problematic when washing her hands, her face, or brushing her teeth. Resident #20 said the faucet had no adjustment knobs. She said the faucet was an auto-censored faucet so when she first put her hands under the faucet, the water came out too cold and then it got too hot for her tolerance. Resident #20 said she worried about getting burned by the faucet water. Resident #20 said the faucet made it difficult for her to wash her hands and face or brush her teeth properly. Resident #20 said the concern about the auto-censored faucets was brought up at the resident council meeting a couple of months ago and a grievance was filed but the problem continued. C. Record review A resident filed grievance dated 9/13/24 revealed that Resident #20 filed a grievance that the newly installed automatic faucet was installed without prior notice. The grievance read Resident #20 said this was her home. The resident reported since the new faucet was installed, the water got too hot and there was no way to adjust the water temperature. Resident #20 wanted her old faucet back. -The grievance form had no documentation of a resolution. IV. Resident #13 A. Resident status Resident #13, age less than 89, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included facial skin cancer, anxiety and asthma. The 8/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent with self-care tasks such as personal hygiene, oral hygiene, toileting and dressing. B. Resident interview (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 was interviewed on 11/19/24 at 10:32 a.m. Resident #13 said she did not like the new faucet because it was too hard to get a comfortable water temperature. She said the water was either too cold or too hot which made it hard to wash her face properly. Resident #13 said she told nursing staff about her concern but nothing had been done to correct the problem. V. Staff interviews The maintenance director (MTD) was interviewed on 11/21/24 at 11:00 a.m. The MTD said all of the residents' faucets were converted from a traditional faucet, with hot and cold adjustment knobs, to automatic faucets. The MTD said the facility made the change in an effort to provide an additional measure of infection control by preventing cross contamination of residents and staff associated with having to touch potentially contaminated faucets during use. The MTD said the faucets were rated as compliant with the Americans with Disability Act (ADA), however, after the installation of the automatic faucets, the facility changed a couple of the residents' faucets back to manual control faucets due to the resident's inability to manage the automatic faucet. The MTD said the facility had not identified issues with the automatic faucets for any other residents. The director of nursing (DON) was interviewed on 11/21/24 at 5:36 p.m. The DON said the decision to convert the faucets was solely a maintenance decision. The DON said the facility had not conducted an accessibility assessment for each resident before the faucets were changed to automatic faucets and, as a result, the facility had replaced a few of the automatic faucets back to manual faucets with the hot and cold faucet adjustments.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on interviews and record review, the facility failed to ensure one (#18) of one resident out of 22 sample residents was kept free from abuse. Specifically, the facility failed to identify a pattern of concerns regarding the care provided by certified nurse aide (CNA) #1 in order to prevent an incident of verbal abuse by CNA #1 toward Resident #18. Findings include: I. Facility policy and procedure The Alleged or Suspected Violations of Patient or Resident Rights policy and procedure, dated September 2022, was provided by the director of nursing (DON) on 11/21/24 at 6:32 p.m. It read in pertinent part, All procedures will follow the elements of the Elder Justice Act which describes the responsibilities for long term care providers, caregivers - paid or volunteer, home health providers or any facility staff who provide direct care to an at-risk elder. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, or deprivation of an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Verbal abuse is any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, patients or their families within hearing distance, regardless of their age, ability to comprehend or disability. Neglect is failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Neglect occurs on an individual basis when a patient or resident has a lack of care in one or more areas. Procedure: When an alleged violation is reported to any employee by a resident, visitor or employee, or is observed or suspected by any employee it will be reported to the immediate supervisor, charge nurse or department head. The department head will immediately notify the administrator. The incident must be reported to the state within 24 hours after the incident occurs except incidents with serious bodily injury and suspected or known criminal activity. Reportable violations include verbal, mental, sexual or physical abuse, corporal punishment, involuntary seclusion, neglect or misappropriation of property. The alleged violation will be thoroughly investigated by the department head or designee. This investigation will begin promptly after the report of the problem. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If a specific employee is named in the alleged violation, that person will be subject to immediate suspension, pending investigation. II. Resident #18 A. Resident status Resident #18, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right dominant side, cerebral vascular disease (causes damage to blood vessels in the brain), dysphagia (difficulty swallowing), expressive aphasia (difficulty speaking) and major depressive disorder. The 11/4/24 minimum data set (MDS) assessment revealed Resident #18 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #18 was dependent on staff for bed mobility, transfers, toileting and personal hygiene. She used a wheelchair for mobility and was propelled by staff. She was always continent of bowel and bladder. B. Resident and resident's representative interviews Resident #18 was interviewed on 11/18/24 at 2:00 p.m. Resident #18 was able to answer yes or no questions by shaking her head. Resident #18 shook her head yes when she was asked if she had any concerns about care being given by facility staff. She shook her head yes when asked if it was a specific person and shook her head no when asked if that individual still worked at the facility. Resident #18's representative was interviewed on 11/18/24 at 5:17 p.m. The representative said Resident #18 was happy now, but had been treated poorly in the past by a former staff member. She said the former staff member, who was mean to the resident, no longer worked at the facility. C. Record review The comprehensive care plan, updated 10/25/24, revealed Resident #18 was dependent on two staff members to transfer from bed to chair and for getting on and off the toilet. The interventions included keeping the call bell within reach and reminding her to call when she needed to use the toilet. III. CNA #1 history The following information indicated CNA #1 had prior allegations of resident care concerns and the facility failed to take action to prevent the incident of abuse toward Resident #18 on 6/21/24. The 12/5/23 Progressive Discipline and Corrective Action form, provided by the DON on 11/21/24 at 3:00 p.m., documented CNA #1 was disciplined for neglecting to provide care for a dependent resident and not leaving the call light within reach of the resident. CNA #1 was counseled by the DON and provided education on how often a resident should be checked on. CNA #1 was allowed to return to work. There was no additional documentation or further investigation regarding the complaint. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/23/24 handwritten counseling form, provided by the DON on 11/21/24 at 3:00 p.m., documented a resident complained about the way CNA #1 treated and spoke to her. The DON noted she spoke with CNA #1 about how to speak to residents, to always enter the resident's room with a smile and provide the care that was requested. The DON documented she told CNA #1 to slow down and give the residents time with care. There was no additional documentation, further investigation or disciplinary action regarding the complaint. IV. Incident of abuse with Resident #18 on 6/21/24 The abuse investigation, dated 6/21/24, documented the assistant director of nursing (ADON) received a handwritten note from an unidentified staff member, which stated the following: CNA #1 was very rude to Resident #18 and other residents. Resident #18 got upset when she saw CNA #1. CNA #1 would not take Resident #18 out to smoke. The investigation revealed student nurse aide (SNA) #1, who witnessed the incident, said she and CNA #1 entered Resident #18's room. Resident #18 requested toileting assistance and CNA #1 responded she did not have time for this (expletive) today and walked out of the room without providing Resident #18 toileting assistance. Resident #18 said she was fearful of CNA #1. The physician, family, police, resident advocate, adult protective services and the board of nursing were notified. The 6/21/24 social service progress note documented the social service director (SSD) interviewed Resident #18 on 6/21/24 at 11:22 a.m. Resident #18 said she did not always inform the nurse if something was bothering her because she was afraid she would not be provided toileting assistance or be taken outside to smoke. The SSD reassured Resident #18 that she had the right to smoke whenever she liked and she should not be made to feel like an inconvenience to staff. Resident #18 said she was relieved the staff member who was mean to her no longer worked at the facility. A letter written by the facility's human resource director (HRD), dated 6/21/24, was provided by the DON on 11/21/24 at 3:00 p.m. The letter read in pertinent part, Other employees had spoken with the DON many times about the way CNA #1 acted with residents. The DON spoke with CNA #1 each time but reported there was nothing inappropriate that occurred. The HRD asked the DON if she was investigating and speaking with other employees and the DON replied CNA #1 had worked here many years and her decision would stand. The HRD spoke with the ADON on 6/21/24. The ADON said the DON did not want to suspend or terminate CNA #1. The ADON reviewed the abuse guidance with the DON and she then agreed to send CNA #1 home and suspend her from work. The employees said that CNA #1 was rough and swore at the residents. CNA #1 would be easily upset with residents if they needed help. Resident #18 was interviewed by the ADON and the DON and confirmed that CNA #1 was verbally abusive and swore at her many times. Resident #18 was fearful of CNA #1. CNA #1 was terminated for verbal abuse of a resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Staff interviews The DON was interviewed on 11/21/24 at 3:00 p.m. The DON said upon finding the note left for the ADON, she immediately interviewed Resident #18 who expressed she was fearful of CNA #1. She said CNA #1 was suspended pending the investigation for the incident with Resident #18. She said the facility conducted an investigation and, following the investigation, CNA #1 was terminated and no longer worked at the facility. She said all staff were provided re-education regarding the Elder Justice Act and resident rights following the incident. The DON said because Resident #18 was fearful of CNA #1, the facility substantiated CNA #1 had verbally abused Resident #18.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain proper nutrition and personal hygiene for three (#4 and #21) of three residents reviewed out of 22 sample residents. Specifically, the facility failed to: -Provide Resident #4, a resident assessed to need supervision, cueing, encouragement and occasional physical assistance with meals the necessary assistance to eat and maintain proper nutrition; and, -Provide Resident #21 with timely incontinence care. Findings included: I. Professional reference According to the Alzheimer's Association, Food and Eating, 2024, retrieved on 12/2/24, from https://www.alz.org/help-support/caregiving/daily-care/food-eating Proper nutrition is important to keep the body strong and healthy. For a person with Alzheimer's or dementia, poor nutrition may increase behavioral symptoms and cause weight loss. Possible causes of poor appetite could include not recognizing food put on his or her plate. Make meal time calm and comfortable. distractions, too many choices, and changes in perception, taste and smell can make eating more difficult. The following tips can help: Behavior such as pouring a glass of juice into a bowl of soup or other foods are signs that a person with dementia is having difficulty during meal time. Limit distractions. Serve meals in quiet surroundings, away from the television and other distractions. Keep the table setting simple. Provide only the utensils needed for the meal to avoid confusion. Distinguish food from the plate. Changes in visual and spatial abilities may make it tough for someone with dementia to distinguish food from the plate or the plate from the table. Check the food temperature. Offer one food item at a time. The person may be unable to decide among the foods on his or her plate. Serve only one or two items at a time. For example, serve mashed potatoes followed by the main entree. Be flexible with food preferences. The person may suddenly develop certain food preferences or reject foods he or she may have liked in the past. Allow plenty of time to eat. Keep in mind that it can take an hour or more for the person to finish. Eat together so that the person with dementia can follow your lead. Keeping mealtimes social can encourage the person to eat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make the most of the person's abilities. Adapt serving dishes and utensils to make eating easier. You might serve food in a bowl instead of on a plate, or try using a plate with rims or protective edges. A spoon with a large handle may be less difficult to handle than a fork, or even let the person use his or her hands if it's easier. Serve finger foods. Try bite-sized foods that are easy to pick up. Try hand-over-hand feeding. Demonstrate eating behavior by putting a utensil in the person's hand, placing your hand around theirs and lifting both of your hands to the person's mouth for a bite. Address a decreased appetite. If the person has a decreased appetite, try preparing some of his or her favorite foods. You may also consider increasing the person's physical activity or plan for several small meals rather than three large meals. II. Facility policy and procedure The Activities of Daily Living/Care provided for a Dependent Resident, revised June 2023, policy provided by the director of nursing (DON) on 11/22/24 at 5:57 p.m. It read in pertinent part, Policy: A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal oral hygiene. Procedures: All residents will receive the care and services that they need if he/she is unable to do their own ADL care independently. Residents who need extensive assistance with toileting and incontinent care will have assistance from staff: a. Upon rising, before breakfast. b. After breakfast, before AM Activity. c. After AM activity, before lunch. d. After lunch, before PM activity. e. After PM activity, before supper. f. After supper, before bedtime. g. From bedtime to rising, check and change or toilet, every two hours when repositioning and as needed. The facility will ensure that all resident's care plans and diet sheets will be updated as needed with the information from physician orders and therapy and staff will be educated with the information and documented with an education sign sheet. Information will also be shared during daily huddles. Residents will be taken or checked on at least every two (2) hours for repositioning and toileting to help prevent skin breakdowns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents will be assisted per orders from therapy with eating/drinking. The residents that need cueing will have staff sit with them and cue them on taking small bites and swallowing food/ drink before taking another bite/drink. III. Resident #4 A. Resident status Resident #4, age 84, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO) diagnoses included severe vascular dementia with behavioral disturbance, diabetes and nutritional deficiency. The 10/30/24 minimum data set (MDS) assessment revealed the resident had long-term memory deficits, was unable to recall the current season; the location of her room; staff's names or faces; and did not know she was in a long-term care facility. The resident had severely impaired cognitive skills for daily decision making; was unable to focus attention; had disorganized thinking and had an altered level of consciousness. The resident did not display aggressive behaviors and did not reject care assistance. The resident was dependent on staff to complete all ADL tasks including eating. B. Observations During a continuous observation of the lunch meal in the main dining room on 11/18/24, beginning at 11:24 a. m. and ending at 1:35 p.m., the following was observed: At 12:05 p.m., an unidentified certified nurse aide (CNA) served Resident #4 her meal. The CNA removed the covers from the resident's food and set the meal and utensils on the table in front of the resident and walked away. Resident #4 proceeded to attempt to scoop up the food off her plate with a spoon but was unable to get any food onto the spoon and to her mouth. The food fell off the plate with each attempted scoop onto the table onto her lap. This went on for the entire meal. The resident was not provided with any adaptive eating equipment and no staff attempted to assist the resident eat her meal. The resident was only able to consume 25 percent of the meal. The rest of the meal was on the table, on her lap on the floor. At the end of the meal service, an unidentified CNA approached the resident and cleared off the resident's lap. The unidentified CNA transported her away from the table without asking the resident if she felt full or if she wanted more food. During a continuous observation of the evening meal in the main dining room on 11/18/24, beginning at 4:11 p.m. and ending at 5:45 p.m., the following was observed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was served her meal at 5:07 p.m. An unidentified CNA delivered the meal to the resident, then uncovered the food and handed the resident a fork. The resident tried to scoop up food off of her plate but was unsuccessful. The resident put down the fork and after a few minutes picked up a spoon and scooped up some fruit from a small bowl. The resident took a long time to chew and swallow the fruit pieces. In the process of eating the fruit, the resident spilled some juice from the fruit cup on the table. After finishing the fruit from the cup the resident tried diligently to scrape the spilled juice off the table. After some attempts to get the juice off the table, the resident began banging the spoon on the side of the fruit cup for a few minutes. Next, the resident poured a bowl of gravity into the fruit bowl. The resident ate only one bite of chicken from her plate and then proceeded to scrape the chicken from the plate and smash it onto the table. Resident #4 was provided with one four ounce (oz) cup of water, which she drank quickly at the beginning of the meal. At 5:23 p.m. Resident #4 was still chewing on the piece of chicken and began scraping food from her plate onto the floor. CNA #4 removed the empty fruit bowl from the table and brought Resident #4 an eight-ounce cup of juice. The resident ate one more piece of chicken and continued to smash the rest of her food around her table. -Resident #4 only ate her fruit cup and two pieces of chicken. Other than CNA #4 bringing the resident a second cup of juice, no staff offered the resident assistance or encouragement to eat her meal. -Additionally, Resident #4 did not get her prescribed Ensure Pro Max supplement that was to be provided with each meal (see nutrition note below). During a continuous observation of the lunch meal in the main dining room on 11/19/24, beginning at 11:28 a. m. and ending at 12:48 p.m., the following was observed: Resident #4 had already been served her meal. She had a plate of ground beef, sweet potato fries, a piece of chocolate cream pie and a four oz cup that she had already drank. Resident #4 did not have any silverware and she was scooping pieces of pie from the styrofoam plate it was served on. The resident was licking every last piece off of her fingers. After approximately 32 minutes of eating the pie with her fingers, a staff member handed her a spoon and walked away. Resident #4 finished the pie and licked all her fingers and then spent the next 36 minutes scraping the styrofoam plate and the table with her spoon to get every bit of pie from the plate and smeared on the pie from the table. As the resident was trying to find more pie no staff approached to off the resident seconds or the see if they could assist or encourage her to eat her meat and potatoes. Resident #4 did pick up a couple of pieces of ground beef in her fingers and put them in her mouth but did not attempt to eat any more of the beef and she ate none of the potatoes. At 12:50 p.m. an unidentified staff member walked by the resident's table and picked up the empty pie plate up did not communicate with Resident #4. Resident #4 then proceeded to mash the sweet potato fries in her fingers but did not attempt to eat any of them. C. Record review (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's comprehensive care plan had a care focus on nutrition with a current status and a goal date of 10/15/24. The care focus read: the resident had the potential for inadequate food and fluid intake due to dementia. Resident #4 was unaware of her own needs and needed verbal and at times physical cues to engage in food and fluid intake. The goal was for Resident #4 to enjoy her preferences in foods and beverages and to consume an acceptable percentage of her meals. Interventions included: -Resident #4 eats in the main dining room; -Resident #4 cannot make her menu choices with assistance from nursing staff; -Resident #4 was unable to express and recall food and beverage preferences, a current list is kept for the staffs reference to assist in ensuring that she gets their food and fluid preferences; -Resident #4 could drink fluids with setup assistance. Staff would offer the resident fluids of her preference throughout the day to help promote adequate hydration; and, -Resident #4 did not have any difficulty feeding herself or holding silverware, cups, or glasses with tray set up. -However, this intervention was inaccurate. Based on observations (see above) Resident #4 had difficulty scooping food and consuming an acceptable amount of her meal. The 11/6/24 care conference note documented the resident's medical durable power of attorney (MDPOA) was not available at that time. The assistant director of nursing (ADON) would visit with the family on 11/7/24. The resident's body weight was 125 pounds (lbs) on 10/22/24, a significant change due to weight loss. The resident needed full assistance with meals. The resident had been ill. The diet consistency was mechanical solids cut foods in small pieces and nectar thick liquids Provide extra gravy or broth on the side and 120 cubic centimeters (cc) of Ensure Pro Max, three times a day with meals. Meals supplemented with five ounces (oz) of fruit cup at 3:00 p.m.; 120 cc of Mighty Shake at 3:00 p.m. and 120 cc of apple juice at bedtime, for weight loss. The resident was observed and consumed approximately 48 percent of the offered meals and consumed approximately 53 percent of the daily recommended fluids this past week. There were no dietary issues at this time. The 11/6/24 interdisciplinary team (IDT) met for a care plan review. The MDPOA was unable to attend but was updated today. Resident # 4 was unable to feed herself due to severe dementia and she no longer engaged in placing food in her mouth, she would bang her spoon and stir food. Resident #4 depended on the staff to perform all ADL tasks and had a significant change due to weight loss. D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 11/20/24 at 3:30 p.m. CNA #3 said Resident #4 was known to not be a good eater and did not like staff assistance. CNA #3 said Resident #4 only needed set-up assistance and she was able to eat her meal on her own but staff should offer her assistance if she was not eating or having trouble eating. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 11/21/24 at 4:45 p.m. The DON said that as far as she was aware Resident #4 was getting better and was now feeding herself. The DON said she was in the dining room on 11/19/24 during lunch but she had not noticed that Resident #4 was scraping pie off of the table. The DON said the staff should assist any resident with eating if they were struggling with the meal. 50853 IV. Resident #21 A. Resident status Resident #21, age 70, was admitted on [DATE]. According to the CPO, diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, type 2 diabetes mellitus with diabetic neuropathy (nerve condition causing pain) and polyarthritis (arthritis affecting at least five different joints). The 11/4/24 MDS revealed Resident #21 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #21 was dependent on staff for bed mobility, transfers, toileting and personal hygiene. The MDS assessment documented Resident #21 was frequently incontinent of urine. B. Resident interview and observations Resident #21 was interviewed on 11/18/24 at 11:00 a.m. Resident #21 said she required assistance of two CNAs and a mechanical lift to transfer. She said she would like to get out of her wheelchair more and lie down in her bed during the day. Resident #21 said if she did not get out of her wheelchair, she did not get her incontinent brief changed. Resident #21 said she had been up in her wheelchair today since before breakfast at about 7:30 a.m. Resident #21 said when she was in her room the call light was not always within reach and her roommate would push her call light to get staff assistance. Resident #21 said last weekend she was left in her wheelchair in the solarium (the sitting room in the center of the facility with many windows) from after breakfast until late in the afternoon. She said she was soaked with urine and the staff had to give her a shower. Resident #21 said she knew the staff were busy that day, but while she was in the solarium she did not have a call light to call for staff or have anything to drink. Resident #21 said she told the DON about this after it happened. On 11/18/24 at 11:00 a.m. Resident #21 was sitting in her wheelchair beside her bed. Her call light was behind her on the bed. Resident #21 was unable to reach the call light. On 11/18/24 at 12:10 p.m. Resident #21 was sitting in her wheelchair in the dining room. She said she had asked staff if someone could take her back to her room. On 11/18/24 at 2:12 p.m. Resident #21 was lying in her bed. She said the staff brought her back to her room after lunch, laid her down and changed her brief. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #21 said she had not been repositioned or changed for approximately five hours (7:30 a.m. to 12:30 p.m.). C. Record review The comprehensive care plan, documented Resident #21 was dependent on staff for transfers, toileting and toileting hygiene. Interventions included using a Hoyer lift (a mechanical lifting device for persons unable to stand or bear weight) for transfers, monitoring for incontinence, changing the resident's brief as needed, providing hygiene after voiding, offering a bedside commode for bowel movements or bladder elimination and assisting to use the bathroom to empty her bladder upon arising, before and after meals, at bedtime, before and after activities and as needed. D. Staff interviews CNA #2 was interviewed on 11/21/24 at 9:06 a.m. CNA #2 said residents who were incontinent or needed staff assistance to use the bathroom should be checked on about every one to one and a half hours. CNA #2 said if the resident did not need to be changed or needed the bathroom, the staff should reposition the resident. CNA #2 said Resident #21 used the bedside commode at times or they laid her down to change her brief. CNA #2 said if Resident #21 did not want to lay down because she wanted to go to an activity or something, they would offer to lay her down just long enough to change her brief and then put her back in her wheelchair. The DON was interviewed on 11/20/24 at 3:57 p.m. The DON said this past Sunday, 11/17/24, Resident #21 was left in the solarium from the time she was assisted out of bed (about 10:30 a.m.) until about 3:00 p.m. The DON said during this time, Resident #21 was not assisted to the bathroom or checked for incontinence. The DON said Resident #21 was soaked with urine and needed a shower when staff assisted her from the solarium. The DON said the staff should have checked on Resident #21 every one to two hours and offered her assistance with toileting. The DON said she spoke with the staff who were working and re-educated them on the importance of checking on residents who are dependent for care and assuring they receive the appropriate care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50853 Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in one of two medication carts and two of two medication storage rooms. Specifically, the facility failed to: -Ensure expired medications were removed from the medication carts and medication storage rooms; and, -Ensure the temperature of the medication storage refrigerator and the vaccine storage refrigerator were checked and recorded daily. Findings include: I. Professional reference The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 11/25/24 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it. The Center for Disease Control (CDC) Vaccine Storage and Handling Toolkit (3/29/24) was retrieved on 11/25/24 from https://www.cdc.gov/vaccines/hcp/downloads/storage-handling-toolkit.pdf. It read in pertinent part, Refrigerators should maintain temperatures between 36 F (degrees Fahrenheit) and 46 F. Temperatures should be checked and recorded at start of each workday. Staff should review and analyze temperature data at least weekly for any shifts in temperature trends. II. Manufacturer's guidelines According to the manufacturer's guidelines for Semglee insulin pen, retrieved on 11/25/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020563s172,205747s008lbl.pdf, Keep your Semglee in cool storage at 36 F to 46 F until first use. Do not allow it to freeze. Once you take your Semglee out of cool storage, for use or as a spare, you can use it for up to 28 days. According to the manufacturer's guidelines for Basaglar insulin pen, retrieved on 11/25/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/205692s019lbl.pdf, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Throw away the pen you are using after 28 days, even if it still has insulin left in it. Store unused pens in the refrigerator at 36 F to 46 F. III. Observations On 11/20/24 at 3:00 p.m. the medication storage room on the Cottage secured hall was observed with registered nurse (RN) #1. The following item was found: -One bottle of Systane Balance eye drops (lubricating eye drops) 10 milliliter (ml) bottle with an expiration date of October 2024. On 11/20/24 at 3:15 p.m. the medication cart on the long term care hall was observed with licensed practical nurse (LPN) #1. The following items were found: -One bottle of calcium 500 milligram (mg) chewable with an expiration date of January 2024; -One Semglee insulin glargine pen opened 10/22/24 (29 days prior); -One Basaglar insulin pen opened 10/22/24 (29 days prior); -One bottle of Oysco (calcium with vitamin D) 500 mg with an expiration date of October 2024; and, -One bottle of antacid (calcium carbonate) 500 mg with an expiration date of October 2024. On 11/20/24 at 3:25 p.m. the medication storage room on the long term care hall was observed with LPN #1. The refrigerator where insulin and vaccines were stored did not have a temperature recorded on 14 out of 31 days in October 2024. IV. Staff interviews LPN #1 was interviewed on 11/20/24 at 3:25 p.m. LPN #1 said medications should be removed from the medication cart when they expire. LPN #1 said it was important to check the temperature of the refrigerator where insulin and vaccines were stored because they have to be kept at a certain temperature range to maintain their effectiveness. The director of nursing (DON) was interviewed on 11/20/24 at 3:57 p.m. The DON said the medication storage refrigerator temperatures should be checked and recorded every day. The DON said the night shift nurses were responsible for checking and recording the temperatures. The DON said all nurses were responsible for checking the expiration dates on medications and removing expired medication from the medication carts and storage rooms. The DON said the nurses should check the expiration date before they take a new medication from storage.

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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** 50853 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. Specifically, the facility failed to: -Ensure residents were offered hand hygiene prior to eating; -Ensure hand hygiene was performed appropriately while serving meals and assisting residents with eating; -Ensure housekeeping staff disinfected high touch surfaces (call lights, bed controls, hand rails and light switches) in resident rooms; -Ensure gloves were changed and hand hygiene was performed appropriately when needed during the cleaning of residents' rooms. Findings include: I. Failure to ensure residents were offered hand hygiene prior to eating A. Observations During a continuous observation on 11/18/24, beginning at 11:24 a.m. and ending at 12:15 p.m., the following was observed: A hand sanitizing wipe dispenser was located inside the door of the dining room. There were hand wipes sticking out of the top of the station that were dried out and a trash receptacle at the bottom. Resident #21 was pushed into the dining room by an unknown staff member. Resident #21 wiped debris off of the table with her hand. An unidentified certified nurse aide (CNA) brought a disinfectant wipe to Resident #21's and cleaned the table. -The CNA did not offer hand hygiene to Resident #21 after watching the resident wipe the dirty table with her hand. Resident #5 wheeled himself into the dining room in his wheelchair using his hands to propel the wheelchair. -Resident #5 was greeted by staff and provided drinks but was not offered hand hygiene after his hands had been touching the dirty wheels of his wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #25 wheeled himself into the dining room in his wheelchair using his hands to propel the wheelchair. -Resident #25 was not offered hand hygiene after his hands had been touching the dirty wheels of his wheelchair. Resident #36 walked into the dining room pushing his walker. He was assisted to sit at the table. -Resident #36 was not offered hand hygiene after having his hands on his walker handles. On 11/20/24 at 11:24 a.m. Resident #25 wheeled himself into the dining room in his wheelchair using his hands to propel the wheelchair. Resident #25 was not offered hand hygiene after his hands had been touching the dirty wheels of his wheelchair. B. Staff interviews CNA #5 was interviewed on11/20/24 at 11:32 a.m. CNA #5 said the residents washed their hands in their room before they brought them to the dining room. She said if a resident wheeled themselves down in their wheelchair they would offer hand sanitizer to them before they came into the dining room or take them to the sink in the dining room to wash their hands. CNA #5 did not know what the hand wipe station was for or if there were wipes in it. The infection preventionist (IP) was interviewed on 11/21/24 at 10:00 a.m. The IP said residents should be offered hand hygiene prior to meals. The IP said residents could wash their hands in their room before they came to the dining room, but if they wheeled themselves in a wheelchair or used a walker they should be offered hand hygiene when they got to the table. She said staff should provide a hand sanitizing wipe when the resident entered the dining room. She said she was not aware that the wipes in the dispenser were dried out. II. Failure to ensure staff hand hygiene was performed appropriately while serving meals and assisting residents with eating A. Facility policy and procedure The Handwashing policy, revised June 2023, was provided by the director of nursing (DON) on 11/21/24 at 2:06 p.m. It read in pertinent part, Purpose: to reduce the risk of infection by the transmission of recognized or unrecognized sources of infection. Hand hygiene should be performed after touching a resident or a resident's immediate environment. B. Observations During a continuous observation of the dining room on the secured unit on 11/18/24, beginning at 11:03 a.m. and ending at 1:30 p.m., the following was observed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two residents were observed in the common room/dining room wandering around the room touching several items in the room. As lunchtime arrived the two residents were encouraged to sit at their dining table. -The two residents were not offered hand hygiene after touching multiple items before they ate their meals. One resident was observed eating part of his meal with his hands. A dining staff member plated the resident's meals and the certified nurse aides (CNA) picked up the residents' trays and delivered them to the residents, setting up the meal for each resident and assisting other residents get seated at their tables. Staff were observed touching residents and table surfaces and not performing hand hygiene in between picking up and delivering each resident's meal tray. CNA #6 sat between two residents who were dependent upon staff to eat their meals. CNA #6 provided total eating assistance to both residents, intermittently alternating assistance between the two residents. CNA #6 handled each resident's silverware, cups and straws, as well as the resident's napkins to assist them with eating. CNA #6 did not perform hand hygiene at any time as she assisted the two residents to eat. During a continuous observation of the main dining room on 11/18/24, beginning at 11:24 a.m. and ending at 12:25 p.m., the following was observed: A hand sanitizer dispenser was located in the dining room near the kitchen door, easily accessible to staff. A handwashing sink was located on the other side of the dining room and was accessible to staff. CNA #3 was serving lunch in the main dining room. She took a pen from her pocket and wrote down the lunch order for Resident #21 on a meal ticket. CNA #3 took the ticket to the kitchen tray line, returned to the dining room with a lunch tray for another resident and placed the plates on the table. -CNA #3 did not perform hand hygiene after using the pen from her pocket and serving lunch to the resident. -CNA #3 proceeded to get another lunch tray from the kitchen and served a second resident without performing hand hygiene. CNA #3 assisted the second resident with putting her napkin on her lap and cutting up her meat. -CNA #3 did not perform hygiene after assisting the second resident and proceeded to serve drinks and lunch to a third resident. CNA #3 assisted the third resident with unrolling the napkin from her silverware and uncovering her bowls. CNA #3 washed her hands with soap and water after assisting the third resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After washing her hands, CNA #3 served drinks to a male resident, touching the table and the resident's walker. CNA #3 then touched the back of another resident's chair, pulled the pen from her pocket and wrote the other resident's order on a meal ticket. CNA #3 proceeded to the kitchen and brought a lunch tray to Resident #21, unrolling and touching her silverware and then putting the napkin on her lap. -CNA #3 did not perform hand hygiene after touching the other resident's chair and using the pen in her pocket before serving Resident #21 her meal and touching the resident's silverware with her hands. During a continuous observation of the main dining room on 11/18/24, beginning at 4:43 p.m. and ending at 5:17 p.m., the following was observed: CNA #4 served dinner to a resident and walked into the kitchen rubbing the back of his head and neck with his right hand. CNA #4 then sat down to assist a resident with eating his dinner. -CNA #4 did not perform hand hygiene after rubbing the back of his head and neck before assisting the resident to eat. CNA #4 got up from the table where he was assisting the resident, performed hand hygiene and served dinner to another resident. CNA #4 took a pen from his pocket and wrote an order on a tray ticket. CNA #4 touched his mask and his neck, put his hand in his pocket and took the meal ticket to the kitchen. -CNA #4 returned to assisting the first resident with eating his dinner without performing hand hygiene. C. Staff interviews The IP was interviewed on 11/21/24 at 10:00 a.m. The IP said staff should perform hand hygiene when serving meals after they touched anything other than the tray and the plate they were serving. III. Failure to ensure housekeeping staff disinfected high touch surfaces, changed gloves and performed hand hygiene appropriately during the cleaning of residents' rooms. A. Professional reference According to The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 11/26/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Common high-touch surfaces include: -bedrails; -IV (intravenous) poles; -sink handles; -bedside tables; -counters; -edges of privacy curtains; -patient monitoring equipment (keyboards, control panels); -call bells; and, -door knobs. B. Facility policy and procedure The Housekeeping policy, revised September 2023, was provided by the DON on 11/21/24 at 2:06 p.m. It read in pertinent part, Occupied resident room cleaning procedure: Follow standard wet dusting procedure. Use a systematic process dusting from top to bottom, obtain a clean water solution and change gloves for each resident area in the room at the divider curtain. The Handwashing policy, revised September 2023, was provided by the DON on 11/21/24 at 2:06 p.m. It read in pertinent part, Perform hand hygiene immediately after removing gloves. C. Observations During a continuous observation on 11/20/24, beginning at 9:48 a.m. and ending at 10:14 a.m., the following was observed: Housekeeper (HSKP) #1 was cleaning room [ROOM NUMBER], a double occupancy room. HSKP #1 gathered supplies, entered the room and donned (put on) gloves. HSKP #1 prepared his cleaning solution with two rags. He took one wet rag from the container and began wet mopping side two of the room. He wiped down the windowsill, closet door and handles, tables and side two of the sink area. -HSKP #1 did not wipe the resident's call light or bed control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSKP #1 took the second rag from the container of cleaning solution and began wet mopping side one of the room. He wiped side one's closet doors and handles, the bathroom and room door handles and side one of the shared sink area. -HSKP #1 did not change gloves and perform hand hygiene in between cleaning side two and side one of the room. -HSKP #1 did not wipe the resident's call light, bed control or light switch on side one of the residents' room. HSKP #1 proceeded to clean the inside of the toilet with a toilet brush and wiped the toilet base and the toilet seat with one of the rags previously used in the residents' room. -HSKP #1 did not change gloves or perform hand hygiene after cleaning the inside of the toilet bowl before cleaning the base of the toilet and the toilet seat. -HSKP #1 did not clean the hand rails in the bathroom or the portable commode used by the resident on side one of the room. HSKP #1 returned his cleaning supplies to his cart and removed his gloves. He swept and mopped the room. -HSKP #1 did not perform hand hygiene after removing his gloves. D. Staff interviews HSKP #1 was interviewed on 11/20/24 at 10:14 a.m. HSKP #1 said he did not know he should have changed gloves when he changed rags and moved to the second side of the residents' room. HSKP #1 said he performed hand hygiene when he was finished with the room and before he began cleaning another room. The housekeeping supervisor (HSKS) was interviewed on 11/21/24 at 11:12 a.m. The HSKS said housekeepers should change their rags and gloves when moving from one side of the room to the other. The HSKS said staff should clean the high touch surfaces daily, including hand rails in the bathroom. The IP was interviewed on 11/21/24 at 10:00 a.m. The IP said housekeepers should clean high touch surfaces in residents' rooms daily. The IP said portable commodes in resident rooms should be cleaned and disinfected. The IP said gloves should be changed between sides of the room in double occupancy rooms and hand hygiene performed when removing soiled gloves to prevent cross contamination. 41032