STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165543	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Park Centre	500 First Street North Newton, IA 50208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, record review, resident, family and staff interview and policy review, the facility failed to accurately assess and prevent a pressure wound to 1 of 3 residents reviewed for pressure ulcers (Resident #54). The nursing staff identified a pressure wound caused by the Ankle/Foot Orthotic (AFO) splint to right foot and continued to utilize the AFO for transfers, resulting in a wound that needed a higher level of treatment. The facility reported a census of 65 residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] for Resident #54 revealed a diagnosis of a Stroke with aphasia (difficulty speaking) and right sided hemiplegia (paralysis), Diabetes Mellitus and end stage renal disease and received hemodialysis via the peripherally inserted central catheter (PICC) access (a long, flexible tube inserted into a vein in the arm). The Brief Interview for Mental Status (BIMS) revealed a score of 14 which suggested an intact cognition. The MDS documented that the resident was at risk for developing pressure ulcers/injuries. The MDS did not document unhealed pressure ulcers/injuries. The document titled Base line Care Plan Summary dated 11/14/24 for Resident #54 revealed current skin integrity issue as redness of coccyx, no further skin integrity issues and directed staff to encourage good nutrition and hydration in order to promote healthier skin and to follow protocols for treatment of injury. The document titled Nursing Assessment on admit for Resident #54 dated 11/14/24 revealed self-care performance for dressing required 1 person and for transfers 2 persons to physically assist with a cane mobility device. The document titled Clinical Admission with the date 11/14/24 documented the only skin concern as; redness of coccyx area. A document titled Patient Discharge and Transfer Form dated 11/14/24 identified devices to assist Resident #54 as a walker, a specialty mattress, and glasses. The orders failed to identify a prosthetic or an AFO. Therapies ordered as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Dialysis. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
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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 0686 Level of Harm - Actual harm Residents Affected - Few	Progress note on 12/30/24 for Resident #54 revealed: 1. Skin issue #1 to right chest, port for dialysis. 2. Assistive device listed as 1/2 side rail, hemi walker and brace used for right upper extremity with transfers. 3. PT, OT, ST, the resident continues to participate in therapy as ordered. Progress note on 1/6/25 at 2:47 PM for Resident #54 revealed: 1. A new skin issue to right lateral foot, a scab in place, with redness noted to surrounding skin. 2. Appears area was related to his brace worn to right lower extremity, brace off until healed. Progress note on 1/7/25 at 2:05 PM for Resident #54 revealed: 1. New wound care orders. 2. Antibiotic ordered for 7 days. 3. Therapy aware of needing to evaluate his brace to right lower extremity. 4. Not wearing brace. The Physician Orders for Resident #54 failed to contain an order for a brace or AFO to right foot. A document titled Physical Therapy PT Evaluation & Plan of Treatment dated 11/14/24 for Resident #54 revealed: 1. Patient will demonstrate stand supported for greater than 3 - 5 minutes in order to increase participation with activities of daily living (ADL) tasks. 2. Patient will demonstrate improved functional lower extremity strength as evidenced by an improved score to 3 on the 30 second sit to stand test. 3. Patient will improve ability to safely transfer to a standing position from sitting in a chair, wheelchair or the side of the bed with supervision or touching assistance with ability to right self to maintain balance. 4. Patient will improve ability to safely transfer from lying on back to sitting on the side of the bed with no back support. 5. Patient will improve ability to safely transfer from bed to chair. 6. Patient will navigate 4 stairs with a rail to safely enter /exit home. 7. Patient will safely ambulate on level surfaces 200 feet using a hemi walker. 8. The PT evaluation failed to address or recommend an AFO to the right lower extremity, foot or ankle. A document titled Microbiology Culture Final for Resident #54 revealed: 1. The sample was collected on 1/15/25 from right foot wound. 2. A heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA). During an observation on 1/21/25 at 3:39 PM Resident #54 was in a bariatric bed with head at the top of the mattress and his feet inches away from the foot board of the bed. Resident did not have the anti-embolism socks on and had a wound to his right lateral foot the approximate size of a silver dollar. The wound was uncovered and had a small amount of drainage on the bed. During an interview on 1/21/25 at 3:39 PM Resident #54's wife stated he was admitted on [DATE] after a stroke for dialysis and therapy for strengthening. The wife stated he had a splint applied to the right foot that caused the open wound and the nursing staff continued to use the splint after finding the wound. Documents titled Skin and Wound Evaluation for Resident #54 revealed an in-house acquired pressure wound to right lateral (outside) mid-foot: 1. Date 1/15/25, measured 1.8 centimeters (cm) x 1.4 cm x (unable to measure as wound bed as it contained 50% slough (dead skin debris) and 50% eschar (black dead skin) with a light seropurulent (combination of pus and serous fluid) drainage, evidence of infection. Unknown how long the wound was present. 2. Date 1/19/25 measured 1.8 cm x 1.8 cm x not applicable (100% slough). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/23/24 at 11:10 AM, Staff G Physical Therapist (PT) stated Resident #54 arrived on admit wearing a right ankle foot orthotic (AFO). Staff G stated therapy staff was walking Resident #54 while he was wearing the AFO, and stated that type of AFO is usually changed to a different type of walking splint, But that takes a while. During an interview on 1/23/25 at 8:56 AM, Staff F, Licensed Practical Nurse (LPN) stated the night nurse would assist the Certified Nursing Assistant (CNA) to get Resident #54 dressed, put the anti-embolism socks and brace on, before he went to dialysis in the mornings. E-mail on 1/23/25 at 2:40 PM, The Director of Nursing wrote in regards to Resident #54 that they attempted to add additional nutritional support for the last couple of months with the wife continuing to refuse. The DON wrote, When the area was first noted, we encouraged staff to only use the brace upon transferring, once we noted the wound worsening, we did hold the brace completely. The house wound nurse assessed on 1/15/25 and notified (the provider) of the area to obtain a wound culture and start antibiotics and sent out for additional wound nurse support (local facility that specialized in geriatric care) on 1/20/25 as we believe this wound will be difficult to heal so we want as much support and guidance as we can. A document titled Wound Treatment Plan dated 1/24/25 revealed: 1. Resident #54 did wear an AFO to his foot and now had a pressure wound so they are not using the AFO. 2. Resident #54 is taking Bactrim (antibiotic) for the foot wound. 3. Skin inspection: pressure ulcer right foot that measures 2.5 cm x 1.6 cm x 0. 3 depth, 20% deep tissue injury with small amount of exudate (drainage). 4. Discontinue the current treatment. Cleanse with wound cleanser and apply betadine moistened gauze to the wound bead and cover with dry gauze and secure with gauze wrap and tape daily. A policy titled Foot Care dated 1/2025 revealed: 1. Purpose was to prevent infection of the feet. 2. Wash feet well and soak approximately 10 minutes, rinse well and dry between toes. 3. Examine feet carefully for evidence of discoloration, mushy heels, breaks in skin integrity irritation or edema (swelling). 4. Toenails are to be clipped with toenail clippers straight across. 5. Note: The podiatrist or licensed nurse is to provide foot care for all diabetic residents.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 49698

Based on record and document review, staff and family interviews, the facility failed to follow Physical Therapy recommendations regarding the ambulation status for 1 of 3 residents reviewed for falls (Resident #61). Resident #61 was to be an assist of 2, on [DATE] Resident #61 was only provided an assist of 1 which resulted in a fall. Resident #61 was transferred to a tertiary hospital and diagnosed with a right femur fracture that required surgery on [DATE]. Following surgery, Resident #61 was placed in intensive care and subsequently died on [DATE]. The Death Certificate revealed manner of death: complications of femur fracture due to or as a consequence of ground level fall.The facility reported a census of 65 residents.

The facility was notified of the Immediate Jeopardy (IJ) on [DATE] for the immediacy which began on [DATE]. On [DATE], the surveyor reviewed and confirmed the prior actions taken by the facility based upon their investigation were implemented. Therefore, it was determined the IJ was lifted as of [DATE] and the scope and severity was dropped to a G

On [DATE] The Director of Nursing intiated staff education to ensure all nursing staff were aware to check Kardex/Communication tab (computer) update (phone) for the correct and most up to date information before starting each shift for their assigned unit.On [DATE] a Risk Management session was conducted to review incidents, that included root cause analysis. The faciltiy conducted Quality Assurance reviews on [DATE], [DATE], and [DATE] that included communications related to resident changes, and updated Plans of Care.

Findings include:

Review of Admission Minimum Data Set (MDS) dated [DATE] revealed, Resident #61 was admitted from the hospital to the facility for skilled rehabilitation on [DATE] with the goal to discharge home. Diagnoses included; Hypertension, Peripheral Vascular Disease, Renal insufficiency, Paraplegia (paralysis of legs and lower body related to history of a back injury), groin abscess, lymphedema, and cellulitis of right lower leg. Resident #61's Brief Interview for Mental Status (BIMS) of 13, which indicated cognitively intact. On admission MDS indicated Resident #61's impairment to both lower extremities and needing partial/moderate assistance (helper does less than half the effort, helper lifts, holds, and supports trunk or limbs, but provides less than half the effort) for sitting to stand, transfers to and from bed or wheelchair, and walking 10 to 50 feet.

Baseline Care Plan dated [DATE] revealed Resident #61 needed one person physical assist for transfers and walking with the use of a walker. Safety risk indicated Resident #61 had a fall in the past month prior to admission due to weakness while ambulating. Noted skin integrity included right groin, right inner thigh, right inner calf, right heel, and coccyx. Physical Therapy (PT) to be provided to improve functional status.

Resident #61's Orders Summary revealed an order dated [DATE] for PT and Occupational Therapy (OT) to evaluate and treat.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress note dated [DATE] at 9:54 AM stated, Resident #61 told therapy that she would not be walking with a walker, she would be using a wheelchair to walk with and then tried to tell therapy staff that she would fall if they made her use a walker and then pushed into therapy staff attempting to fall. Therapy explained that Resident #61 needs to use walker to work towards independence to go home. Resident #61 continued to attempt to fall on OT staff. Skilled evaluation note dated [DATE] at 10:27 AM revealed, Resident #61 has an unsteady gait and poor balance. Progress note dated [DATE] at 6:43 PM revealed, Resident #61 admitted post hospitalization for right leg and groin abscesses, skilled level of care (SNF LOC) to work with therapy, currently assist of 2 for ambulation with wheelchair to follow, stand pivot for transfers. Progress note dated [DATE] at 5:19 AM revealed, Resident #61 continues SNF LOC post hospitalization for leg wounds. Lung sounds clear to auscultation, shortness of breath noted with exertion. Resident up with assist of 1 and walker for toileting and moving to bed. Review of Resident #61's Care Plan initiated on [DATE] revealed, Resident #61 required assist of 2 and Front Wheel [NAME] (FWW) for transfers, required assist of 2 and FWW during ambulation in room with wheelchair to follow, and only stand pivot transfers. Progress note dated [DATE] at 7:15 AM revealed, Resident #61 was being transferred to the bathroom with assistance of CNA, gait belt, and walker. CNA reported falling with resident #61 in the bathroom. When this nurse walked into Resident#61's bathroom she was lying on the floor with legs out in front of her and her back up against the wall in the shower. Resident #61 reported that she had hit the back of her head, right lower extremity with outer rotation. Resident unable to move at initial assessment. Resident #61 had non-skid socks on. This nurse went to call the physician to get an order to send to the ER to evaluate and treat. Progress note dated [DATE] at 10:48 AM revealed, Resident #61's Representative called and said Resident broke her femur. Orthopedics had been called to see if they are going to do surgery. Facility's Discharge Summary note dated [DATE] at 1:06 PM revealed, Resident #61 had a femur fracture due to a fall and was sent to ER via ambulance. Resident #61's Representative stated Resident will be at the hospital for weeks and does not want to hold the bed. Review of Facility Provided Investigation dated [DATE], revealed the following: 1. On [DATE] Resident #61 was admitted as an assist x1 for transfers, ambulation, and toileting from hospital. Nursing review and this is acceptable as the Resident did well and reported limitations. Baseline Care Plan started upon admission after completion of assessment and review. Nursing staff in the unit made aware of status. 2. On [DATE] Incident occurred with therapy, resulting in therapy recommendation changing Resident #61 to assist x2 with no ambulation; OT reported Resident #61 was attempting to fall into her and refused to use a walker for ambulation as she wanted to use a wheelchair to walk with as she did at home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. On [DATE] Interdisciplinary Team (IDT) notified of incident during rounding; IDT and nursing staff discussed and determined no ambulation would hinder Resident #61's progress and would continue using Baseline Care Plan information as there were no reports of fall or incident during hospitalization . Nursing staff reported no concerns of Resident #61 attempting to fall into them. Nursing staff also reported Resident #61 requested FWW for ambulation attempts and refused to use a wheelchair while in her room. 4. On the evening of [DATE] Resident #61's status update for PT was provided to MDS nurse for Resident #61 to be assist x2 with wheelchair to follow. Therapy recommendation was developed as a result of the encounter with OT on ,d+[DATE]. Nursing staff continue to use the Baseline Care Plan based off IDT's review on [DATE]. 5. Interview on [DATE], Staff H, CNA RA (restorative aide), determined she asked her peer Staff E, CNA about Resident #61's transfer status prior to working with her. 6. Interview on [DATE], Staff E, CNA, reported status of transfer and ambulation for Resident #61 as an assist x1 with FWW and toileting as an assist x1 since admission. 7. Facility reviewed Resident #61's progress notes and Point of Care (POC) charting on [DATE] which reflected Resident #61 as an assist x1 for transfer, toileting, and ambulation. After occurrence with OT there is one progress note indicating Resident #61 was assist x2 for a short period ([DATE] at 6:43PM) next note and all following indicated assist x1 with FWW with no difficulty. 8. Therapy notes reviewed on [DATE], stated Resident #61 needed limited assistance (assist x1 with FWW) for transfer and ambulation. Facility Provided Investigation dated [DATE] stated; Upon completion of investigation, it was determined Staff H, CNA RA, was using safe transfer technique as well as fall interventions were in place at time of incident. Prior to the incident occurring there is no record of knee buckling in Resident #61's history that the facility was made aware of. Nursing staff were following the Baseline Care Plan at the time of the incident. Review of Facility's Investigation included statement by Staff H, CNA RA, on [DATE] revealed Staff H, CNA RA stated Resident #61 had said she tripped over the transition strip from the room to the bathroom, Staff H reported being clear of this transition and were halfway into the bathroom when the fall happened, making it impossible for Resident #61 to trip on the transition strip. Staff H, CNA RA also stated she spoke with the Therapy team and they advise her, Resident #61's update was that way because when working with OT Resident #61 was acting like she was going to fall several times and kept saying, I (Resident #61) cannot walk without my wheelchair as my walker or I will fall Review of PT Discharge Summary, end of care date [DATE], revealed Resident #61 was walking with aide to the bathroom and had a fall. Resident was sent to the hospital with a fractured femur. Skilled services provided included, gait training, therapeutic exercise, therapeutic activity, and balance training. Resident #61 was assist x2 with staff for gait and transfers. During an interview on [DATE] 11:39 AM, DON stated there was no documentation of the IDT meeting on [DATE] when it was determined Resident #61 would continue as an assist x1 instead of Physical Therapy's recommendation of an assist x2 with FWW and wheelchair to follow. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Facility's Self Report submitted on [DATE] by DON (Director of Nursing) to Iowa Department of Inspections, Appeals, and Licensing (DIAL) revealed the following: 1. Incident Summary: Timeline of Incident: On [DATE] at approximately 8:50 AM, DON was notified Resident #61 had a fall and was sent to the ED on [DATE] for evaluation. Facility staff were notified of confirmed fracture at approximately 12:00 PM and Resident #61 would be admitted to the hospital. Staff H, CNA RA, stated she was assisting Resident #61 with getting ready for the day, she went into Resident #61's room and asked if she was ready to get up for the day. Resident #61 stated she was and needed the restroom. Staff H, CNA RA, stated she grabbed the gait belt, her walker, and ensured Resident #61 had her gripper socks on. Resident #61 sat up independently on the side of the bed and waited for Staff H. Staff H, CNA RA, secured the gait belt on Resident #61 and placed the walker in front of her. Resident #61 stood without difficulty and started to ambulate to the restroom. Resident #61 entered the restroom and started to side step, Staff H, CNA RA, asked Resident #61 if she was ok. Resident #61 reported she needed to sit on the toilet. Staff H, CNA RA, reminded Resident #61 she needed to get closer to the toilet and Resident #61 fell straight down on the floor. Staff H, CNA RA, reported she had a hand on the gait belt, however it occurred quickly therefore unable to slowly lower Resident #61 to the floor. Staff H, CNA RA ensured Resident #61 was safe and as if she was okay. Resident #61 reported her right leg hurt a little. Staff H, CNA RA placed a pillow behind Resident #61's head for comfort and immediately called for the nurse. Staff I, RN responded to Resident #61's room and completed a full head to toe assessment and obtained vitals. RN's assessment revealed external rotation of the right lower extremity and noted the right lower extremity was shorter than the left. Facility Physician was notified and an order to send Resident #61 to ER was obtained. Ambulance arrived at 7:30 AM and left facility with Resident #61 at 8:00 AM. Resident #61's Representative was notified at approximately 7:26 AM. Hospital notes state: Severe osteoarthritis both hips, greater in the right. Moderately displaced impacted spiral fracture proximal right femur shaft and negative for acute intracranial process. Corrective Action Description: Facility immediately initiated investigation and additional information will follow, Facility respectfully requests to provide further information and updates as appropriate and/or it occurs. 2. Amendment Details: On [DATE] Liaison notified Facility, Resident #61 passed away on [DATE]. Suspected related to known peripheral vascular disease that resulted in multiple prolonged hospital stays prior to skilled stay at Facility. Post-surgical notes state risk of surgical repair include; bleeding, infection, nerve injury, muscle damage, malunion of fractures, nonunion of fractures, need for additional procedures. Resident #61 opted for surgery and underwent surgical repair the morning of [DATE]. Surgery went well without complications noted. Overnight Resident #61 went into A-Fib and respiratory failure resulting in ICU admission and intubation with initiation of pressor support. Family met and discussed current condition along with past several months of ongoing medical concerns and determined Resident #61 should be placed on comfort measures and extubated around 9:30 AM. Resident #61 passed around 9:40 PM on [DATE]. 3. On [DATE] at 4:06 PM Report status changed to Pending Review by DIAL. 4. On [DATE] at 2:49 PM Report status changed from Pending Review to No Investigation by DIAL. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:24 PM Staff C, LPN explained the process when Therapy determines new recommendations. Staff C, LPN revealed therapy will notify the nurses with a form that indicates the recommendations. The Nurse will then note recommended changes in Resident's #61 Electronic Health Record (EHR). The Kardex (plan of care used by CNA staff) will be updated by the nurse, when this is done a notification will show up on CNA's phones to make them aware of the changes. Therapy will give a copy of the recommendations to the MDS coordinator to update Resident' s MDS and Care Plan. During an interview on [DATE] at 1:20 PM, Staff J, Physical Therapist (PT) stated OT had done an evaluation the morning of [DATE], Resident #61 had made statements of falling, after this encounter OT recommended Resident #61 be an assist x2. Later that day Staff J, PT had evaluated Resident #61, stating she had done well functionally ambulating from her bed to the bathroom. On the way back to Resident #61's bed, she became weak and tired. Staff J, PT had to get a wheelchair and placed behind it behind Resident #61 to prevent her from falling. Due to Resident #61's low stamina, Staff J, PT recommended Resident #61 have an assist of 2 using FWW and wheelchair to follow due to the risk of fatigue and falls. During an interview on [DATE] 2:01 PM, Facility's Medical Director stated he would expect nursing staff to follow Therapy's recommendations. Facility's Medical Director also confirmed, he does sign off and approve Therapy's recommendations, If therapy recommended a Resident to be an assist x2, staff should be following these recommendations and provide the assistance of 2. Review of Resident #61's Certificate Of Death revealed, Resident #61 died on [DATE] at 9:36PM, with Manner of Death: Accident, Immediate Cause of Death: Complications of femur fracture, due to or as a consequence of: ground level fall. Review of Facility provided Ambulation Policy originated ,d+[DATE] revealed Facility's procedure is to check resident's medical records for any ambulation related order, note equipment ordered if any and check Care Plan for level of assistance with ambulation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on observation, policy review, and staff interviews, the facility failed to ensure water temperatures at points of delivery did not exceed safe maximum temperatures for 4 of 6 resident room sinks and for 1 of 3 shower rooms. The facility reported a census of 65 residents. Findings Include: Temperature readings obtained by the State Agency on 1/22/25 revealed the following concerns: 8:15 a.m. room [ROOM NUMBER] bathroom sink 127.7 F(Fahrenheit) 8:20 a.m. room [ROOM NUMBER] bathroom sink 126.4 F 8:26 a.m. South Sunset Shower room [ROOM NUMBER].4 F 8:38 a.m. room [ROOM NUMBER] bathroom sink 125.4 F 8:42 a.m. room [ROOM NUMBER] bathroom sink 121.6 F Temperature readings obtained by Staff B Maintenance Staff on 1/22/25 revealed the following concerns: 8:49 a.m. room [ROOM NUMBER] bathroom sink 125.2 F. Staff B stated that's not good while he obtained this temperature. 8:52 a.m. room [ROOM NUMBER] bathroom sink 124.5 F. After the temperature measurements, Staff B stated water temps should be less than 120 F and stated he would adjust the mixing valve to add more cold. On 1/22/25 at 1:02 p.m., Staff B rechecked the sinks in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and the South Sunset Shower room and all temperatures measured less than 112 F. The facility policy Water Systems: Hot Water Temperature Readings, revised 9/2019, directed staff to maintain hot water temperatures at 110 degrees F in all resident areas. On 1/23/25 at 10:27 a.m., the Executive Director stated that the acceptable water temperature range was 100-120 F. The stated after the high temperatures yesterday, the facility increased the frequency of checks. She stated they would discuss the concern in their Quality Assurance(QA) meetings to decide the frequency of monitoring moving forward. Based on observations, staff interviews, and facility policy the facility failed also to ensure water temperatures at points of delivery did not exceed safe maximum temperatures for 4 of 6 resident room sinks and for 1 of 3 shower rooms. The facility reported a census of 65 residents.