STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065169	A. Building B. Wing	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Pueblo	1601 Constitution Rd Pueblo, CO 81001

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 0689 Level of Harm - 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** 46022 Based on observations, record review and interviews, the facility failed to ensure three (#4, #3, and #6) of four residents reviewed for accidents out of six sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to develop and implement a person-centered care plan that identified Resident #4's fall risk and put effective interventions into place to reduce falls and prevent an injury. Resident #4 was admitted to the facility for long term care on 2/15/22 with a diagnosis of Lennox-gastaut syndrome (seizure disorder), diabetes mellitus type two, gastro-esophageal reflux disease (GERD), and chronic pain syndrome. On 2/16/22, one day after the resident's admission to the facility, the resident sustained a fall. The facility failed to put effective interventions into place and the resident fell again on 2/19/22 (four days after his admission) and 2/20/22, for which he sustained a left humerus fracture. After the resident sustained a left humerus fracture on 2/20/22, the resident sustained an additional four falls on 3/17/22, 3/26/22, 5/4/22, and 5/30/22. The facility failed to determine the root cause of the resident's continued falls and put effective, person-centered interventions into place. Additionally, the facility failed to: -Conduct a root cause analysis and update the plan of care with effective person-centered approaches for Resident #3 and Resident #6; and, -Ensure a registered nurse (RN) assessment was completed and documented following sustained falls by Resident #4, Resident #3, and Resident #6. I. Facility policy and procedure The Fall Prevention Program policy, dated November 2020, was provided by the nursing home administrator (NHA) on 7/8/22 at 10:48 a.m. It revealed, in pertinent part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A 'fall' is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. Low/Moderate Risk Protocols: -Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: a clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed, call light and frequently used items are within reach, adequate lighting and wheelchairs and assistive devices are in good repair. Implement routine rounding schedule, monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. Encourage residents to wear shoes or slippers with non-slip soles when ambulating. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. Monitor vital signs in accordance with facility policy. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program: indicate fall risk on care plan, place Fall Prevention Indicator (such as star, color coded sticker) on the nameplate to resident's room and place Fall Prevention Indicator on resident's wheelchair. Implement interventions from Low/Moderate Risk Protocols. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status or recent change in functional status. Provide additional interventions as directed by the resident's assessment, including but not limited to: assistive devices, increased frequency of rounds, sitter, if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education and therapy services referral. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. II. Failure to implement effective person-centered interventions to prevent falls A. Resident #4 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Resident status Resident #4, under the age of 65, was admitted on [DATE]. According to the July 2022 computerized physician orders (CPO), the diagnoses included Lennox-gastuat syndrome (seizure disorder), diabetes mellitus type two, gastro-esophageal reflux disease (GERD) and chronic pain syndrome. The 5/27/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of one out of 15. He required supervision for transfers, toileting, personal hygiene and limited assistance of one person for dressing. It documented the resident had two or more falls in the last 90 days. 2. Resident observations On 7/6/22 at 3:17 p.m. Resident #4 was lying in bed without a urinal within reach. -At 4:37 p.m. Resident #4 was sitting in his wheelchair in his room. Anti-rollbacks were not observed on the resident's wheelchair and a urinal was not within reach (see interventions documented on the fall risk care plan). On 7/7/22 at 12:06 p.m. Resident #4 was sitting in his wheelchair. The wheelchair did not have anti-rollbacks. 3. Record review The fall risk care plan, initiated on 2/16/22 and revised on 2/23/22, documented the resident was at risk for falls related to seizures, a new environment, weakness and decreased mobility from a recent hospitalization . The interventions included: providing anti-rollbacks to his wheelchair (5/31/22), assisting the resident to the toilet when he was restless (3/26/22), encouraging the resident to have proper footwear when out of bed (2/16/22), encouraging the resident to wait for assistance (3/26/22), ensuring the resident was positioned correctly during meals (3/17/22), placing a fall mat at the bedside (5/4/22), offering assistance to transfer when in the room (add date), offering a urinal to keep at his bedside (3/30/22), reassuring the resident that staff will allow him to complete tasks with supervision (2/20/22) and reminding the resident to use his call light (2/16/22). The cognitive care plan, initiated on 2/17/22, documented the resident had impaired cognition, dementia, or impaired thought process related to difficulty making decisions, impaired decision making, neurological symptoms and seizures. The interventions included: administering medications as ordered, asking yes or no questions in order to determine the residents needs, communicating with the family, identifying staff and explaining care prior to beginning, monitoring changes in cognitive status, keeping the residents routine consistent, presenting one thought at a time, reminiscing with the resident using photos of family, reviewing medications and using task segmentation to support the residents cognitive deficits. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated on 2/22/22, documented the resident had an ADL self-care performance deficit related to encephalitis (swelling of the brain), Lennox-gastaut syndrome and weakness. The interventions included, in pertinent part, the resident required limited to extensive assistance with bed mobility, required extensive assistance with personal care, toileting and transfers. The 2/15/22 admission fall risk assessment identified the resident as a low fall risk. a. Fall incident on 2/16/22-unwitnessed The 2/16/22 nursing note documented at 12:37 p.m., Resident #4 was found sitting on the floor by his bed, one day after his admission to the facility. The immediate intervention put into place was to encourage the resident to call for assistance. -It did not give any further details of the resident's fall. The 2/16/22 change of condition assessment documented the resident did not use his call light for assistance when he was found sitting on the floor next to his bed. The 2/16/22 incident report documented the resident sustained an unwitnessed fall without injury. The resident denied hitting his head or any pain and there were no predisposing environmental factors. It indicated the resident had a gait imbalance, was recently admitted to the facility and was ambulating without assistance. The 2/16/22 interdisciplinary team (IDT) review documented the resident sustained an unwitnessed fall without injury. The resident did not use his call light to ask for assistance. The intervention included the staff should offer the resident assistance with transferring and encourage the resident to use his call light. The fall risk baseline care plan, developed on 2/16/22, included interventions such as encouraging the resident to wear proper footwear on when up, encouraging the resident to call for assistance as needed and offering assistance to transfer from the bed or wheelchair when staff were in the room. The 2/16/22 fall risk assessment, completed after the resident sustained the fall, documented the resident continued to be a low risk for falls. -The facility failed to determine the cause of the resident's fall, in order to put effective interventions in place to prevent further falls. b. Fall incident on 2/19/22-unwitnessed The 2/19/22 change of condition assessment documented the resident sustained an unwitnessed fall. It indicated the resident appeared to be unsteady when ambulating. The 2/19/22 incident report documented Resident #4 was found lying on his left side on the floor in the bathroom. The resident reported he had slipped. The resident was assessed and did not sustain any injuries. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 2/19/22 fall risk assessment documented the resident was at high risk for falls. The 2/20/22 IDT review documented the resident sustained an unwitnessed fall in his bathroom without injury on 2/19/22. The resident was attempting to self-toilet. The intervention documented for staff to offer toileting assistance to the resident when they were in the resident's room. c. Fall incident on 2/20/22-unwitnessed with a sustained major injury The 2/20/22 change of condition assessment documented Resident #4 appeared to have pain in his left arm, left shoulder, and was holding his left wrist. The resident had bruising to his mid upper left arm and swelling to his left shoulder, all sustained from an unwitnessed fall. The physician was notified and ordered an x-ray of the left shoulder, left humerus, and left wrist. The 2/20/22 nursing progress note, documented the facility received the radiology report that the resident sustained an acute fracture of the left humeral neck with minimal displacement from an unwitnessed fall. The physician assistant was notified and orders were obtained to stabilize the resident's left shoulder and administer pain medication as needed. The 2/20/22 fall risk assessment documented the resident was a high risk for falls. The 2/21/22 IDT progress note documented the resident was reviewed for an unwitnessed fall with complaints of pain to the left shoulder and arm. The resident had bruises on the left arm. The resident was weak, unsteady and continued to transfer on his own without calling for assistance. The intervention included offering the resident assistance to transfer or use the toilet when staff were in his room. -However, this intervention was also recommended and updated on the care plan for the 2/19/22 fall. A new person-centered fall intervention was not put into place after the resident sustained a fall with major injury on 2/20/22. -The resident's medical record did not include any additional information about the fall, indicating the facility failed to conduct a root cause analysis of the fall. d. Fall incident on 3/17/22-unwitnessed The 3/17/22 change of condition assessment documented the resident sustained an unwitnessed fall in his room. Resident #4's roommate initiated the call light to alert staff that Resident #4 had fallen. The resident was sitting on the side of his bed and reached for his meal that was placed on his bedside table. Upon reaching for the food, the resident slid off the edge of the bed and onto the ground. The 3/18/22 IDT review documented the resident sustained an unwitnessed fall without injury on 3/17/22. The intervention documented was to ensure Resident #4 was positioned correctly at meals. e. Fall incident on 3/26/22-unwitnessed The 3/26/22 change of condition assessment documented the resident sustained an unwitnessed fall in his bathroom. The resident had no complaints of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 3/26/22 incident report documented the resident was found on the floor of his bathroom. The resident had a gait imbalance and was ambulating without assistance. The 3/27/22 IDT progress note documented the resident sustained an unwitnessed fall, while attempting to toilet himself. It indicated the care plan was reviewed and updated. -The intervention included keeping a urinal at the resident's bedside. However, observations during the survey process showed a urinal was not present in the resident's room nor at the bedside (see observations above). f. Fall incident on 5/4/22-unwitnessed The 5/4/22 change of condition assessment documented the resident sustained an unwitnessed fall. When the certified nurse aide (CNA) answered the resident's call light, he was found on the floor next to his bed. The resident reported he slid out of bed. The resident was wearing slip-resistant socks. The 5/4/22 incident report documented the same details of the resident's fall from bed. The 5/4/22 fall risk assessment documented the resident was at high risk for falls. The 5/4/22 IDT progress note documented putting fall mats in place while the resident was in bed. g. Fall incident on 5/30/22-unwitnessed The 5/30/22 change of condition assessment documented the resident was found laying on the floor next to his bed. The resident reported he slid out of his bed while transferring without assistance to use the bathroom. The 5/30/22 incident report documented the resident sustained an unwitnessed fall in his room. The resident reported he was attempting to use the restroom. The resident had a gait imbalance, was ambulating without assistance, and fell during a transfer. The 5/30/22 fall risk assessment documented the resident was a high risk for falls. The 5/31/22 IDT review documented the resident sustained an unwitnessed fall. He was attempting to use the bathroom by himself. The intervention documented was for physical therapy to evaluate for anti-rollbacks for the wheelchair. The care plan documented the resident was to have anti rollbacks to his wheelchair starting on 5/31/22. -However, observations (see above) revealed the resident did not have anti rollbacks in place. -A review of the physical therapy notes revealed the resident received physical therapy for four weeks (6/1/22 to 6/28/22) and was not evaluated for anti-rollbacks for his wheelchair. B. Resident #3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Resident status Resident #3, age 86, was admitted on [DATE]. According to the July 2022 CPO, the diagnoses included diabetes mellitus type two, heart failure, hypertension (high blood pressure), dementia, irritable bowel syndrome, and history of falling. The 6/21/22 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of three out of 15. He required extensive assistance of one person for bed mobility, transfers, dressing, toileting and personal hygiene. It documented the resident had two or more falls in the last 90 days. 2. Observations On 7/7/22 at 10:55 a.m. Resident #3 was lying in bed. CNA #1 confirmed there was not a motion sensored night light in Resident #3's room as indicated in the fall risk plan of care (see below). 3. Record review The fall risk care plan, initiated on 1/27/22, documented the resident was at risk for falls related to poor safety awareness, diabetes mellitus, atrial fibrillation (a-fib), heart failure, and a history of falls. The interventions included: anticipating and meeting the resident's needs (1/27/22), assisting the resident to transfer to his wheelchair when he is awake or restless (4/23/22), educating staff on encouraging toileting prior to laying down after meals (1/27/22), encouraging the resident to have an assistive device within reach (2/26/22), encouraging the resident to wear non-skid socks (4/23/22), ensuring frequently used items were within reach (1/27/22), providing a motion sensor night light in the resident's room (3/9/22), offering to assist the resident with toileting when staff were in the resident's room (2/11/22), offering the resident extra blankets at night (2/28/22), an evaluation by physical therapy (5/25/22) and placing the residents wheelchair at his bedside (2/16/22). The ADL care plan, initiated on 1/27/22, documented the resident had an ADL self-care performance deficit related to heart failure, a-fib, and cognitive deficits. The interventions included, in pertinent part: the resident required limited to extensive assistance with personal hygiene, required extensive assistance with toileting and transfers. The admission fall risk assessment documented on 1/21/22, identified the resident at a high fall risk. a. Fall incident on 2/10/22-unwitnessed The 2/10/22 nursing progress note documented at 10:32 p.m., Resident #3 was found on the floor. The resident reported he had used the restroom without assistance. The 2/10/22 change of condition assessment documented the resident had an unwitnessed fall. The resident was found on the floor in his room. The resident reported he was attempting to use the restroom. Upon RN assessment there were no injuries noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 2/10/22 incident report documented the resident reported he fell in his room after using the restroom. The resident was confused, incontinent and had a gait imbalance. The resident had ambulated without assistance. The 2/10/22 fall risk assessment documented the resident was at high risk for falls. The 2/11/22 IDT progress note documented the resident sustained an unwitnessed fall without injury. The intervention was documented to offer the resident assistance with toileting during rounding. b. Fall incident on 2/26/22-unwitnessed The 2/26/22 change of condition assessment documented the resident was attempting to check the air vent and was found on the floor at 3:45 a.m. -It did not document any immediate interventions put into place to prevent further falls. The 2/26/22 incident report documented the resident was unsteady on his feet and was not using any assistive devices when he fell . The 2/26/22 fall risk assessment documented the resident was at high risk for falls. The 2/26/22 IDT progress note documented the resident sustained an unwitnessed fall without injury. The intervention was documented to encourage the resident to call for assistance and keep an assistive device within reach. -However, the resident's care plan documented the intervention to place the resident's wheelchair at the bedside on 2/16/22, ten days prior to the residents fall on 2/26/22. The 2/28/22 IDT review documented for staff to provide additional blankets to the resident at night. c. Fall incident on 3/8/22-witnessed The 3/8/22 nursing progress note documented at 7:15 p.m., Resident #3 was observed falling in his room. The resident was unable to report why he was out of bed. The resident sustained a superficial scratch to his left shoulder. -It did not document any immediate interventions put into place to prevent further falls. The 3/8/22 incident report documented the resident was standing in his room when staff observed him fall to the ground. The resident was unable to recall what he was doing. The resident was confused, incontinent, had gait imbalance, impaired memory, and weakness. The 3/8/22 fall risk assessment documented the resident was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 3/9/22 IDT progress note documented the resident had a fall on 3/8/22. The resident reported he was attempting to use the restroom and did not call for assistance. The resident had recently been discharged from therapy services. The intervention was documented to place a motion sensor night light in the resident's room. -However, during observations (see above) the resident did not have a motion sensor night light in his room. d. Fall incident on 4/23/22-unwitnessed The 4/23/22 nursing progress note documented at 10:22 p.m., Resident #3 was found on the floor next to his bed. -It did not include any other details of the fall. The 4/23/22 incident report documented the resident was found on the ground next to his bed. There was poor lightning in the resident's room at the time of the fall. -It did not include any additional details of the fall or any immediate interventions to prevent further falls. The 4/27/22 IDT review documented the resident was reviewed for a fall on 4/23/22. It indicated the resident was being treated for a urinary tract infection. -No intervention was put into place to prevent Resident #3 from sustaining further falls after he fell on [DATE]. e. Fall incident on 5/20/22-unwitnessed The 5/20/22 nursing progress note documented at 8:35 a.m., Resident #3 sustained a fall and hit the back of his head on his wheelchair. The resident reported pain to the right side of his forehead about one hour after the fall. The physician ordered for the resident to be sent to the emergency room for evaluation. The 5/20/22 incident report documented the resident had attempted to transfer himself to the toilet when he fell to the ground. The resident reported hitting his head when he fell . The 5/25/22 IDT progress note documented the resident was reviewed for a fall on 5/20/22. The resident was attempting to use the restroom when he sustained a fall and hit his head. The intervention documented physical therapy to evaluate the resident. A review of the physical therapy notes revealed the resident was on physical therapy services from 4/21/22-6/22/22. -The resident was already receiving physical therapy as a fall prevention intervention from 5/20/22. f. Fall incident on 6/23/22-unwitnessed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 6/23/22 change of condition assessment documented the resident sustained an unwitnessed fall. The resident had an increased temperature, non productive cough and increased fatigue for one week. -It did not include any further details of the fall. The 6/23/22 incident report documented the resident was found on the floor near his bed. The resident reported pain to his left hand. -It did not include any further details of the fall or any immediate interventions put into place. The 6/24/22 IDT review documented the resident sustained a fall on 6/23/22. The resident was tested for COVID-19, which resulted in a negative. -No interventions were put into place to prevent the resident from sustaining future falls. C. Staff interviews CNA #1 was interviewed on 7/7/22 at 10:55 a.m. She said person-centered fall interventions should be documented on the resident's care plan. She said when management placed a new fall intervention in place, they would notify the floor staff verbally of the new intervention. CNA #1 said Resident #4 had frequently fallen when he was attempting to use the restroom without assistance. She said Resident #4 had a fall mat next to his bed to prevent injuries. CNA #1 said the nursing staff were doing frequent rounding, every 30 minutes, to check on Resident #4, however they had not been doing the frequent rounding for several weeks. CNA #1 said Resident #3 had cognitive impairment and was unable to use his call light appropriately. She said Resident #3 often fell when he was attempting to use the restroom without assistance. The NHA and the director of nursing (DON) were interviewed on 7/7/22 at 4:04 p.m. The NHA said person-centered interventions should be implemented to prevent residents from falling. The DON said the floor staff should put interventions in place to keep the resident safe immediately following a fall. The NHA said the IDT reviewed the fall the next business day and put an intervention into place. She said the minimum data set coordinator (MDSC) was responsible for updating the resident's care plan with new interventions. The DON said Resident #4 had sustained several falls since his admission to the facility. She said he fell several times within the first week he was admitted and one of the falls resulted in a left humerus fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON said the resident did not use the call light when he needed assistance. She said the facility had not implemented a toileting program after the resident sustained three falls while he was attempting to use the bathroom by himself. She said the facility had not implemented interventions to help prevent the resident from sustaining further falls with major injury. The DON said Resident #3 had sustained several falls since he was admitted to the facility. She said the resident was confused and unable to use the call light appropriately. She said the staff were to offer toileting during rounding. She said the resident did not have a toileting program in place. The NHA said the IDT team had discussed removing the motion sensored night light as they found it was not effective. The DON said the facility had not implemented person-centered interventions to prevent the resident from continued falls. 38185 D. Resident #6 1. Resident status Resident #6, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the July 2022 CPO, the diagnoses included quadriplegia (paralysis of all limbs) and dementia without behavioral disturbance. The 6/8/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required total dependence upon staff for assistance with all activities of daily living (ADLs). It indicated the resident had sustained one fall since the prior assessment period with no injury. 2. Resident interview Resident #6 was interviewed on 7/7/22 at 3:53 p.m. She said she had fallen from the wheelchair a few times. She said the facility staff would take her to her room after she ate her meals in the dining room. She said they would leave her facing the window, sitting in her wheelchair. She said she had asked the facility staff on multiple occasions to put her back to bed after she finished her meals because it was uncomfortable and hurt to sit up in the wheelchair for long periods of time. The resident said she started falling asleep in the wheelchair and would slip out and onto the ground. She said the facility staff always told her she slipped out of the wheelchair on purpose. She said she was barely able to move her arms and thought it was ridiculous that the facility staff thought she was able to purposely move herself out of the wheelchair and onto the ground. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Pueblo	1601 Constitution Rd Pueblo, CO 81001

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F 0689 Level of Harm - Actual harm Residents Affected - Few	She said in the past two months, she had gotten better about not falling asleep in the wheelchair and that was why she had not had a fall recently. She said the facility never evaluated her for a new wheelchair, cushion or any other steps to prevent her from falling out of her wheelchair. 3. Record review The fall risk care plan, initiated on 7/3/19 and revised on 2/14/22, documented the resident was at a moderate risk for falls due to deconditioning, gait/balance problems and a diagnosis of quadriplegia. It indicated the resident would gain momentum by moving her head and torso and scoot herself out of the wheelchair when she was upset. The interventions included anticipating the resident's needs to decrease unsafe behaviors that may cause injury to herself or others, assisting the resident with safe positioning in the wheelchair, ensuring the resident's call light is within reach and encouraging the resident to use the call light for assistance, using pillows to assist with positioning in bed for comfort and safety, reassuring the resident that her needs will be met, reassuring the resident that staff will assist her to bed if she asks them and when the resident was in her room and sitting in the wheelchair, offer to assist the resident to bed, especially when she is observed to be angry or upset. -These interventions were put into place upon the resident's admission to the facility (7/3/19) until 12/30/2020. The 12/31/21 fall risk assessment documented the resident as a low risk for falls. a. Fall incident on 2/14/22 The 2/14/22 interdisciplinary (IDT) progress note documented a housekeeper observed the resident sliding down from her wheelchair and onto the foot pedals. It indicated a skin assessment, pain assessment and fall risk assessment were completed and the physician was notified. It documented the staff should assist the resident to reposition in her wheelchair as needed as she would scoot herself forward, monitor the resident per protocol and the resident's care plan was reviewed and updated. -However, upon review of the resident's fall risk care plan, it had not been updated with any additional interventions for the fall on 2/14/22. The 2/14/22 incident report documented the resident slid out of her wheelchair and onto the foot pedals. The resident was calling for a nurse and a housekeeper was walking by the resident's room and saw the resident out of her wheelchair. The resident's back was resting against the seat of the wheelchair with her legs extended out in front of her. The resident said she slid out of the wheelchair because she wanted to go to bed after lunch. It indicated the resident did not sustain an injury. -It did not include any additional interventions to prevent further falls from the resident's wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. Fall incident on 3/24/22 The 3/24/22 situation, background, assessment and recommendation (SBAR) documented the resident slid out of the wheelchair and onto the floor. It indicated the resident as assessed and did not sustain an injury. It did not include any immediate interventions to prevent further falls from the resident's wheelchair. The 3/25/22 IDT progress note documented the resident was up in her wheelchair, scooted forward and slid out of the wheelchair onto her buttocks. A skin assessment, pain assessment and a fall risk assessment were completed and the physician was notified. The interventions included encouraging the resident not to scoot forward in the wheelchair, assisting the resident to bed when she was restless and monitoring the resident according to the facility protocol. The 3/24/22 incident report documented the resident slid out of the wheelchair, onto the floor and onto her buttocks. It indicated the resident was placed back into bed. It did not include any interventions to prevent further falls from the resident's wheelchair. Upon review, the resident's care plan was updated on 3/25/22 to include if the resident was up in her wheelchair and becoming restless, assist the resident out of her wheelchair and into bed. -However, the same intervention had been in place since 10/24/2020, indicating to assist the resident to bed when she was angry or [TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure two (#4 and #3) of three out of six sample residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being. Specifically, the facility failed to adequately monitor residents nutritional status and put effective interventions in place to prevent significant weight loss. Resident #4 was admitted to the facility for long term care on 2/15/22 with a diagnosis of Lennox-gastaut syndrome (seizure disorder), diabetes mellitus type two, gastro-esophageal reflux disease (GERD), and chronic pain syndrome. When the resident was admitted to the facility he weighed 122 pounds (lbs). The facility failed to adequately monitor Resident #4's nutritional status by implementing effective nutrition interventions to prevent significant weight loss. The resident sustained a 15.6% (19 lbs) weight loss in four months, which was considered significant. Additionally, Resident #3 was admitted to the facility for long term care on 1/21/22 with a diagnosis of diabetes mellitus type two, heart failure, dementia, and irritable bowel syndrome. When the resident was admitted to the facility he weighed 156.5 lbs. The facility failed to adequately monitor Resident #3's nutritional status by implementing effective nutrition interventions to prevent significant weight loss. The resident sustained a 12.5% (19.5 lbs) weight loss in six months, which was considered significant. Findings include: I. Facility policy and procedure The Weight Assessment and Intervention policy, revised September 2008, was provided by the director of dining (DOD) on 7/7/22 at 2:44 p.m. It revealed, in pertinent part, The nursing staff will measure resident weights on admission and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Verbal notification must be confirmed in writing. The dietitian will review the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for 'significant' weight change has been met. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe, 3 months- 7.5% weight loss is significant; greater than 7.5% is severe, 6 months- 10% weight loss is significant; greater than 10% is severe. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding: the resident's target weight range (including rationale if different from ideal body weight); the approximate calorie, protein, and other nutrient needs compared with the resident's current intake; the relationship between current medical condition or clinical situation and recent fluctuations in weight; and whether and to what extent weight stabilization or improvement can be anticipated. Interventions for undesirable weight loss shall be based on careful consideration of the following: resident choice and preferences; nutrition and hydration needs of the resident; functional factors that may inhibit independent eating; Environmental factors that may inhibit appetite or desire to participate in meals; chewing and swallowing abnormalities and the need for diet modifications; medications that may interfere with appetite, chewing, swallowing, or digestion; the use of supplementation and/or feeding tubes; and end of life decisions and advance directives. II. Resident #4 A. Resident status Resident #4, under the age of 65, was admitted on [DATE]. According to the July 2022 computerized physician orders (CPO), the diagnoses included Lennox-gastaut syndrome (seizure disorder), diabetes mellitus type two, gastro-esophageal reflux disease (GERD), and chronic pain syndrome. The 5/27/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of one out of 15. He required supervision for transfers, toileting, personal hygiene and limited assistance of one person for dressing. He required setup assistance for meals. It documented the resident had sustained a significant weight loss that was not prescribed by the physician. B. Observations During a continuous observation on 7/7/22 beginning at 11:55 a.m. and ended at 12:30 p.m., Resident #4 was sitting in his room. -At 12:06 p.m. Resident #4 received his lunch of a ham and cheese sandwich and chips. Resident #4 requested a banana. -At 12:13 p.m. an unidentified certified nurse aide (CNA) served Resident #4 a banana. -At 12:27 p.m. an unidentified CNA removed Resident #4's plate from his room. Resident #4 had consumed 100% of his meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The facility did not offer the resident additional food, despite consuming all his food (see interview below). C. Record review 1. Nutritional care plan The nutrition care plan initiated on 2/22/22 and revised on 4/18/22, documented the resident had a nutritional problem or potential for nutritional problems related to Lennox-gastaut syndrome, GERD, diabetes, and hyperlipidemia (high cholesterol). It indicated the resident had dental concerns, needed a softer diet, consumed small amounts of food and reported being particular about the food he consumed. The interventions included administering medications as ordered, determining the residents food preferences (likes Mexican and hamburgers, does not like chocolate), providing diabetic Med Pass (nutritional supplement) as ordered (discontinued on 3/23/22 related to refusals), referring to the interdisciplinary team as needed, providing meal assistance, observing for signs of dysphagia (swallowing difficulties), obtaining and monitoring lab work and providing the diet as ordered. The activities of daily living (ADL) care plan, initiated on 2/22/22 documented the resident had an ADL self-care performance deficit related to encephalitis (swelling of the brain), Lennox-gastaut syndrome and weakness. The interventions included, in pertinent part, the resident required set-up assistance at meals and needed a lot of encouragement to eat adequately. 2. Resident #4's weights Resident #4's weights were documented in the resident's medical record as follows: -On 2/15/22, the resident weighed 122 lbs. -On 3/6/22, the resident weighed 118 lbs. -On 3/31/22, the resident weighed 113 lbs. -On 4/2/22, the resident weighed 113 lbs. -On 4/14/22, the resident weighed 107 lbs. -On 4/20/22, the resident weighed 107.5 lbs. -On 5/3/22, the resident weighed 108 lbs. -On 5/16/22, the resident weighed 99.5 lbs. -On 6/2/22, the resident weighed 100 lbs. -On 6/15/22, the resident weighed 103 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 6/29/22, the resident weighed 103.5 lbs. -The resident sustained a 7.4% (9 lbs) weight loss, which was considered severe, from 2/15/22 to 3/31/22 in one month. -The resident sustained a 7.4% (8 lbs) weight loss, which was considered severe, from 4/20/22 to 5/16/22 in one month. -The resident sustained a 15% (18.5 lbs) weight loss, which was considered severe, from 2/15/22 to 6/29/22 in 5 months. 3. Nutritional assessments/progress notes The 2/21/22 admission nutrition data collection documented that the resident weighed 122 lbs on 2/15/22 and was five feet four inches tall. His body mass index (BMI) was 20.9 and his usual body weight was 122 lbs. The resident had no recent weight changes. The resident's skin was intact, he had his own teeth, and was able to feed himself independently. The resident was on a pureed textured diet and was consuming 50-75% of his meals. It indicated the resident enjoyed chili beans and Mexican food. The assessment summary documented there were no nutritional concerns at that time. The 3/7/22 registered dietitian (RD) assessment documented the residents' estimated nutrition needs were 1725 calories per day, 53-60 grams of protein per day, and 1 milliliter (ml) of water per calorie per day. It documented the resident had unintended weight loss related to prolonged illnesses as evidenced by weight loss and poor intake. He was on a consistent carbohydrate diet with a mechanical soft texture. The resident had fractured teeth related to recent seizures. The resident was averaging 50% intakes at meals and was on weekly weights related to reported weight loss in the hospital. It indicated the RD attempted to call the family to discuss residents' history and goals of care. The RD recommended adding Med Pass 120 ml (milliliters) twice per day. It documented the nutrition goals were to maintain weight with a goal of gaining 1-2% body weight per week and to maintain skin integrity. The 3/23/22 nutrition note documented that the RD recommended discontinuing the Med Pass as the resident was frequently refusing it when it was offered. The residents' meal intake was good, but often varied. It documented the resident's family brought food into the facility. The RD requested a new weight be obtained from the registered nurse (RN) on duty. -The facility failed to obtain a weight as recommended by the RD for nine days. The facility also failed to monitor weekly weights. The 4/18/22 nutrition note documented that the resident weighed 107 lbs on 4/14/22 and sustained a significant weight loss (15 lbs or 12.3% in two months). The physician was notified of the weight loss. The RD discussed the weight loss with the resident's spouse. It documented that the resident's spouse reported the resident had always been a picky eater and she was bringing food and Ensure (nutritional supplement) into the facility for the resident. The resident's spouse said the resident enjoyed hamburgers and Mexican food, but did not like chocolate. The RD recommended reimplementing the diabetic Med Pass 237 ml once per day. The resident continued on weekly weights and staff were to encourage meal intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 4/29/22 nutrition note documented the resident weighed 107.5 lbs. and had gained half a pound in one week. The resident had varying acceptance of the diabetic Med Pass and refused the supplement half of the time. It documented to continue to offer the residents favorite foods to aid in intake. -No further interventions were documented to address the resident's significant weight loss. The 5/4/22 nutrition note documented the resident weighed 108 lbs. The resident's weight had been stable for two weeks and the interdisciplinary team (IDT) and the physician were working to discharge the resident's home due to failure to thrive in the facility. It indicated the resident refused Med Pass and other nutritional interventions. It documented to continue to encourage food and fluids. -However, the only nutrition interventions put into place were to encourage meal intake and diabetic Med Pass. No other nutrition interventions had been recommended or trialed. The 5/4/22 IDT note documented the resident weighed 108 lbs and had sustained a 5 lbs weight loss. It documented the resident did not like the supplements. The facility was considering transferring the resident home, as he was displaying signs of failure to thrive in the facility. -It did not include any nutritional interventions to address the resident's significant weight loss. The 5/11/22 nutrition data collection documented that the resident weighed 108 lbs on 2/15/22 and was 64 inches tall. His BMI was 18.5 and his usual body weight was 108 lbs. It indicated the resident had sustained a significant weight loss, but did not indicate the amount of weight loss or the timeframe. The resident was on a mechanical soft diet and consumed 51-75% of his meals. The assessment summary documented that the resident had a weight loss and multiple interventions have been attempted with no success. It documented the resident was planning to discharge home with his wife soon related to failure to thrive in the facility. -However, the resident's plan of care lacked any documentation of multiple interventions being trialed with the resident, other than Med Pass and providing the resident with foods he enjoyed. The 5/16/22 nutrition note documented the resident weighed 99.5 lbs. The RD reviewed the resident's weight and documented that the resident had sustained further weight loss and decline. It documented the resident continued to accept the diabetic Med Pass half of the time. It documented the RD left a voice message with the physician and resident's spouse to discuss the resident's weight loss. -The RD did not put any immediate interventions into place as the resident continued to sustain significant weight loss. The RD continually documented the resident refused multiple interventions, however failed to document any other interventions that had been attempted with the resident. The facility continually failed to implement a person centered nutritional intervention after the resident sustained a significant weight loss of 7.4% (8 lbs) in one month from 4/20/22 to 5/16/22 and 7.5% (8 lbs) in the three months since his admission to the facility. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 5/25/22 nutrition note documented the RD spoke to the resident regarding his weight loss. At the time of the conversation the resident was in his room with his untouched meal in front of him. The RD offered a meal alternative such as a quesadilla, hamburger, or chicken, which the resident refused. The resident said he did not want a milkshake, but would drink a glucerna (diabetic nutrition supplement) occasionally. The resident said he did not like to eat his meals in the dining room. It documented the RD expressed the importance of eating, maintaining/gaining weight for health, strength, and improving the potential to go home. The RD also expressed concern for his health, weight, and tried to reinforce the need for food. The physician was notified of the weight loss and ordered a therapist to assist with the residents' reported depression. -The recommendation included to continue to encourage the resident to eat and drink, however did not document any significant nutritional interventions. The 6/2/22 nutrition note documented the resident weighed 100 lbs. The RD reviewed the resident's weight and documented that the resident gained weight from the previous week (half a pound). It documented the resident appeared to be eating a bit better at meals. It documented to continue encouraging the resident's meal intake to support weight maintenance and weight gain. - No additional nutritional interventions were added to the resident's plan of care. The 6/8/22 IDT progress note documented that the resident was reviewed for recent weight loss. The resident weighed 100 lbs, which was up half a pound in one week. The resident was being followed by the RD and the resident's spouse had been taking the resident out to eat in the community on the weekends. -No additional nutritional interventions were put into place to promote additional weight gain. The 6/15/22 nutrition note documented the resident weighed 103 lbs. The resident's BMI was 17.7, which was still considered underweight, but had gained 3 lbs. The resident's spouse had been taking the resident out to eat in the community and the resident was consuming 75% of most meals in the past week. The diabetic Med Pass was still in place once per day, but the resident had been refusing it frequently. The RD documented that she would address the possibility of adding an appetite stimulant and to continue to encourage the intake of food and fluid. The 6/29/22 nutrition note documented the resident weighed 103.5 lbs. The RD reviewed the resident's weight and noted he had a positive weight gain. The resident's BMI was 17.8, which was still considered underweight. The resident continued on a carbohydrate controlled diet and was accepting 75% of most meals. The resident was accepting the ordered diabetic Med Pass half of the time. It documented to continue to encourage the intake of food and fluid. -The RD did not document any follow up on the potential appetite stimulant documented on 6/15/22. The facility continued to fail to implement person-centered nutritional interventions after the resident sustained a 15% (18.5%) weight loss in five months, which was considered severe. III. Resident #3 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #3, age 86, was admitted on [DATE]. According to the July 2022 CPO, the diagnoses included diabetes mellitus type two, heart failure, irritable bowel syndrome and history of falling. The 6/21/22 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of three out of 15. He required extensive assistance of one person for bed mobility, transfers, dressing, toileting, and personal hygiene. He required setup assistance at meals. It documented the resident had sustained a significant weight loss that was not prescribed by the physician. B. Observations During a continuous observation on 7/7/22 beginning at 11:55 a.m. and ended at 12:30 p.m., Resident #3 was observed in his room. -At 12:03 p.m. Resident #3 received his lunch meal of meatloaf, mashed potatoes, chicken noodle soup, and a brownie. -At 12:27 p.m. an unidentified CNA entered Resident #3's room to check if he was done eating. The resident had consumed 100% of his mashed potatoes and meatloaf. The resident was still eating his chicken noodle soup and said he wanted to eat his brownie. -The resident consumed all of his foods and was not served or ordered fortified foods to provide additional calories or protein to promote weight gain (see interview below). C. Record review 1. Nutritional care plan The nutritional care plan, initiated on 1/27/22 and revised on 5/16/22, documented the resident had a potential for nutritional problems related to cognitive deficits, atrial fibrillation (a-fib), heart failure and hyperlipidemia (high cholesterol). The resident had a history of being underweight. -On 4/5/22 the resident was trialed on the restorative dining program. The interventions included administering fiber/probiotic/imodium as ordered, administering medications as ordered, providing a carbohydrate controlled and mechanically soft diet, determining the residents likes and dislikes, providing meal assistance as needed, observing the resident for signs or symptoms of dysphagia (swallowing difficulties), observing the resident for signs of malnutrition, obtaining lab work as ordered, offering snacks throughout the day, providing diet as ordered, providing supplements as ordered and for the RD to evaluate and make changes as needed. 2. Resident #3's weights Resident #3's weights were documented in the resident's medical record as follows: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 1/21/22 at 8:42 p.m., the resident weighed 156.5 lbs. -On 1/21/22 at 8:44 p.m., the resident weighed 156 lbs. -On 1/29/22, the resident weighed 146.4 lbs. -On 2/12/22, the resident weighed 147 lbs. -On 2/24/22, the resident weighed 144.2 lbs. -On 3/7/22, the resident weighed 140 lbs. -On 3/15/22, the resident weighed 139 lbs. -On 3/22/22, the resident weighed 142.8 lbs. -On 3/29/22, the resident weighed 142 lbs. -On 4/2/22, the resident weighed 144 lbs. -On 4/5/22, the resident weighed 144.1 lbs. -On 4/13/22, the resident weighed 139.5 lbs. -On 4/21/22, the resident weighed 140.5 lbs. -On 4/28/22, the resident weighed 140.5 lbs. -On 5/3/22, the resident weighed 139 lbs. -On 5/7/22, the resident weighed 139 lbs. -On 5/16/22, the resident weighed 138 lbs. -On 6/2/22, the resident weighed 136 lbs. -On 6/15/22, the resident weighed 137 lbs. -The resident sustained a 6.5% (10.1 lbs) weight loss, which was considered severe, from 1/21/22 to 1/29/22 in one week. -The resident sustained a 12.5% (19.5 lbs) weight loss, which was considered severe, from 1/21/22 to 6/15/22 in six months. 3. Nutritional assessments/progress notes (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 2/1/22 admission nutrition data collection documented that the resident weighed 146.4 lbs and was six feet four inches tall. The resident's BMI was 17.8 and his usual body weight was 146 lbs. The resident did not have any weight changes. The resident's skin was intact, he had natural teeth, and was able to eat independently. The resident was on a no added salt diet and was consuming 75-100% of his meals. It documented the resident did not have any food preferences. It documented there were no nutritional concerns at this time. -However, the resident had sustained a 6.2% (9.6 lbs) weight loss, which was considered severe in one week. The 2/3/22 nutrition note documented that the resident had lost weight since his admission to the facility. The RD documented that she questioned the accuracy of the weight. It documented the RD spoke with the resident's spouse who reported the resident's usual body weight was 137 lbs. It documented the resident could have had weight fluctuations related to heart failure and edema and the RD would conduct a nutritional assessment. The 2/3/33 nutrition RD assessment documented the residents' estimated nutrition needs were 1900 calories per day, 66 grams of protein per day, and 1900 ml of fluid per day. The resident was on a consistent carbohydrate diet and ate meals with set-up assistance from staff. His intake was 75-100% at most meals. The resident had a 10 lbs weight loss since admission, with a BMI of 17.9, which was considered underweight. The RD documented the nutritional goals were to maintain the resident's weight within 5% of 137 lbs or a weight gain towards a BMI within normal limits and to maintain skin integrity. The nutrition interventions included: providing a consistent carbohydrate diet with set-up assistance at meals, monitoring for chewing or swallowing difficulty, monitoring weekly weights and encouraging food and fluid intake. -Regardless of the RD's questioning of the inaccurate weight, she did not recommend a reweigh to clarify the resident's weight or implement a person-centered nutrition intervention to address potential significant weight loss. The RD did not provide education to the resident's spouse that the resident's normal weight of 137 lbs was considered underweight and the risks of the resident continuing to be underweight. The 2/16/22 nutrition note documented that the resident had weight loss and the RD reviewed it. The RD continued to question the accuracy of the resident's admission weight, however did not request the resident to be reweighed. It indicated the resident's weight was stable and he was consuming 76-100% of his prescribed carbohydrate consistent mechanical soft diet. The 3/10/22 nutrition note documented that the resident weighed 140 lbs and the RD reviewed the resident's weights. The resident's BMI was 17, which was considered underweight. The resident was consuming 75% of most meals. It documented that the resident's spouse reported that occasionally the resident's gums became sore from his dentures. The resident's spouse said the resident had Ensure at home, but it caused him to have diarrhea. The resident's spouse said she thought it was appropriate for the resident to trial a nutritional supplement. The RD recommended offering diabetic Med Pass 120 ml twice per day and continuing to monitor weekly weights. -The facility continually failed to provide education the resident and resident's spouse on the risks of the resident returning to a weight of 137 lbs as his BMI would classify him as underweight. (continued on next page)

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	065169	A. Building B. Wing	07/07/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 3/16/22 nutrition note documented that the resident weighed 139 lbs and the RD reviewed the resident's weights. The resident lost 1 lbs in one week and was trending towards his usual body weight of 137 lbs. The resident was accepting the diabetic Med Pass. The 3/23/22 nutrition note documented that the resident weighed 142.8 lbs and the RD reviewed the resident's weights. The resident had gained weight the previous week, but his BMI was 17.4 which still classified him as underweight. The resident was accepting 50-100% of the diabetic Med Pass and consumed 75% of his meals. The 4/4/22 IDT progress note documented that the resident had a 16 lbs weight loss in 90 days. It indicated the resident had episodes of diarrhea that may have contributed to his weight loss. The physician ordered medications to prevent further diarrhea. It documented the facility was monitoring, offering and encouraging snacks. -No other nutritional interventions were put in place to address the significant weight loss of 16 lbs in 90 days. The 4/6/22 nutrition note documented that the resident weighed 144.1 lbs. The resident had lost weight since admission due to trending towards his usual body weight of 137 lbs. The resident gained 2 lbs in one week and was accepting the ordered diabetic Med Pass. The resident's BMI was 17.5, which was considered underweight. It documented to continue with the plan of care and encouraging weight gain if possible. The 4/13/22 nutrition progress note documented that the resident weighed 139.5 lbs and the resident was again trending towards his usual body weight of 137 lbs. The resident was being treated for a urinary tract infection, continued to accept the diabetic Med Pass, and was accepting 75% of his meals. The RD recommended increasing the diabetic Med Pass to 150 ml twice per day. The RD recommended continuing weekly weights and encouraging food and fluid intake. The 4/13/22 IDT note documented that the resident was reviewed for weight loss. The resident weighed 139. 5 lbs, which was close to his reported usual body weight. It indicated the resident was on a restorative dining program and received diabetic Med Pass twice a day. -It did not document any additional nutritional interventions to address the resident's continued significant weight loss and underweight BMI. The 4/26/22 nutrition data collection documented that the resident weighed 140.5 lbs. It indicated the resident had sustained a significant weight loss, but did not indicate the amount of weight lost or the time frame. The resident's weight loss was not prescribed by the physician. It documented there were no nutritional concerns at that time. -However, the assessment documented the resident had no nutritional concerns at the time of the assessment, despite a significant weight change that was not physician prescribed. The 4/29/22 nutrition note documented that the resident weighed 140.5 lbs and the resident's weight had been stable for 45 days. The resident's BMI was still underweight at 17.1, but was still above his usual body weight. It documented to continue the current plan of care. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-However, the resident's weight was not stable as he continued to experience a significant weight loss since his admission to the facility. The 5/4/22 nutrition note documented the resident weighed 139 lbs and the resident's weight was stable. The RD recommended increasing the diabetic Med Pass to 150 ml three times a day and to continue weekly weights. The 5/16/22 nutrition note documented the RD had the resident trail Magic Cup (nutritional ice cream supplement) and he accepted it well. The RD recommended discontinuing the Med Pass and adding the Magic Cup to his lunch and dinner meal trays. The resident weighed 138 lbs and was still underweight with a BMI of 16.8. The resident was consuming 75% of his meals with assistance from a restorative dining aide. The 6/2/22 nutrition note documented that the resident weighed 136 lbs (2 lbs weight loss from the previous nutrition note) and had a weight loss over the last 30 days. The resident was still underweight with a BMI of 16.6. The resident consumed 76-100% of his meals and accepted the Magic Cup. The RD recommended reimplementing the diabetic Med Pass 120 ml twice per day and continuing to monitor weekly weights. -The facility failed to implement person centered nutrition interventions to prevent a 12.5% (19.5 lbs) severe weight loss in six months from 1/21/22 to 6/15/22. Also, the facility failed to implement effective nutrition interventions to promote weight gain to a healthy weight and provide education to the resident and resident's spouse regarding health risks of a low body weight. D. Staff interviews The RD was interviewed on 7/7/22 at 1:38 p.m. She said all residents were weighed upon admission and then weekly for four weeks. She said if the resident's weight was stable, then they were then weighed monthly, but weekly weights would continue if their weight was unstable. She said the restorative nurse aides were responsible for obtaining weights as ordered. She said she was responsible for recommending weekly weights versus monthly weights. She said the physician typically would order weekly or daily weights if the weight fluctuations were related to fluids. The RD said Resident #4's significant weight loss had been a concern. She said he had limited responsiveness to the nutrition interventions that were put into place. The RD said she had recommended diabetic Med Pass, spoke with the physician and resident's spouse, gathered the resident's food preferences, and recommended an appetite stimulant (which, according to the resident's medical record, was not followed up on or implemented). The RD said the resident's spouse would bring in food for the resident, but was unsure how often. The RD said she attempted to speak with Resident #4, however he was primarily Spanish speaking and she was unable to effectively communicate with the resident. She said she did not use an interpreter. She said the resident did not respond to the questions she asked him. The RD said it would be beneficial for facility staff to offer additional food when the resident consumed 100% of his meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD said she had not trialed fortified foods or high calorie/ high protein foods. The RD said she had not discussed liberalizing the resident's diet with the physician and the physician did not have any recommendations regarding Resident #4's significant weight loss. The RD said when a resident had a low BMI they were at a risk for malnutrition, developing pressure wounds and would have a difficult time recovering from an illness. The RD said Resident #3's spouse reported his usual body weight at 137 lbs prior to admission. She said when Resident #3 weighed 137 lbs, he was considered underweight and this could lead to other comorbidities. The RD said she had recommended queuing at meals, Med Pass and Magic Cup as nutritional interventions for Resident #3. The RD said she had not tried fortified foods or high calorie/high protein foods as other nutritional interventions for the resident. The RD said she had not discussed liberalizing the resident's diet with the physician. The RD said since the resident had consumed all of his foods for lunch on 7/7/22, fortified foods could have been beneficial to provide additional calories to promote weight gain. The director of dining (DOD) was interviewed on 7/7/22 at 2:02 p.m. He said Resident #4 enjoyed foods that were on the always available menu. The DOD said the resident was depressed, which led to his poor appetite. He said the resident preferred not to eat most meals. He said Resident #4 preferred to eat in his room, so he was unsure of what he ate. He said he would expect the nursing staff to encourage meal alternatives when taking the resident's meal order. The director of nursing (DON) and nursing home administrator (NHA) were interviewed on 7/7/22 at 4:04 p. m. The DON said Resident #4 was afraid to eat when he admitted , because he was unable to purchase the food. The DON said the facility provided reinforcement that the facility was providing the food at no cos[TRUNCATED]

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure food was labeled and dated; -Ensure the kitchen was clean and sanitary; -Ensure holding temperatures of food were within the safe range; and, -Ensure dishware was dried and stored in a clean and sanitary manner. Findings include: I. Failure to ensure food was labeled and dated correctly A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYliuu2v1G/view. It revealed in pertinent part, A date marking system that meets the criteria stated in (1) and (2) of this section may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (a) of this section; Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this section; or Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the Department upon request. (Retrieved [DATE]). B. Observations On [DATE] at 10:10 a.m. the initial kitchen tour was conducted and the following was observed: -In the dry-storage, an opened bag of corn meal and brown sugar were not labeled. -In the main walk-in cooler, sliced cheese, lettuce, shredded cheese, onion, and tomato did not contain a use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-In a reach-in refrigerator in the main kitchen, there was a container of cantaloupe, cherry jello, sandwiches, shredded cheese and salad mix that were dated with preparation dates, but no use by date. A container of hard boiled eggs was observed without a label or date on it. -In the main kitchen, underneath the preparation table there were four plastic containers that had food thickener, sugar, flour, and bread crumbs that were not labeled or dated. During a continuous observation, on [DATE] beginning at 9:58 a.m. and ended at 10:03 a.m., the following was observed: -In the dry-storage, the opened bag of corn meal remained unlabeled. -In the main walk-in cooler, a container of tomato, a container of onion, and a container of cheddar cheese that did not contain a use by date. There was also an undated box of sausage, undated sliced ham and an undated box of bacon. -In the main kitchen, underneath the preparation table four plastic containers that had food thickener, sugar, flour, and bread crumbs that remained unlabeled or dated. -In a reach-in refrigerator in the main kitchen, sliced cheese, prepared lettuce, salad mix, cooked chicken, two ham and cheese sandwiches, two peanut butter and jelly sandwiches, hard boiled eggs, sliced deli ham, and cottage cheese without use by dates. Two bags of shredded cheese did not have a label or a date. II. Failure to ensure the kitchen was clean and sanitary A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. It revealed, in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Non food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (Retrieved [DATE]) B. Facility policy and procedure The Sanitization policy, revised [DATE], was provided by the director of dining service (DOD) on [DATE] at 2:44 p.m. It revealed, in pertinent part, All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. C. Observations On [DATE] at 10:10 a.m. the initial kitchen tour was conducted and the following was observed: -The ice machine had an orange mold build-up where the ice was dispensed into the holding tank and served to residents. -Behind the deep fat fryer, the surrounding wall and ground was covered in an orange and black film. On [DATE] at 10:30 a.m. the ice machine still had an orange mold build-up where the ice was dispensed into the holding tank and behind the deep fat fryer, the surrounding area had been cleaned from the previous day, but splattered orange and black film remained on the surrounding wall and floor. III. Failure to ensure holding temperatures of food were within the correct range A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. It read in pertinent part; The food shall have an initial temperature of 41 F (fahrenheit) or less when removed from cold holding temperature control or 135 F or greater when removed from hot holding temperature control. (Retrieved [DATE]) B. Facility policy and procedure The Food Preparation and Service policy, revised [DATE], was provided by the DOD on [DATE] at 2:44 p.m. It revealed, in pertinent part, The ' danger zone ' for food temperatures is between 41? (farenheit) and 135?. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. The longer foods remain in the ' danger zone ' the greater the risk for growth of harmful pathogens. Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature ' danger zone ' are discarded after four hours. The Sanitization policy, revised [DATE], was provided by the DOD on [DATE] at 2:44 p.m. It revealed, in pertinent part, Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Observations During a continuous observation on [DATE] beginning at 11:15 a.m. and ended at 1:02 pm. the following was observed: -A tray of individually prepared sour cream containers sitting on the serving line. They were not on ice. -At 1:02 p.m. the DOD took the temperature of the sour cream on a test tray and it read 75?. IV. Failure to ensure dishware was dried and stored in a clean and sanitary manner A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. It read in pertinent part; Unless used immediately after sanitization, all equipment and utensils shall be air-dried. (Retrieved [DATE]) B. Facility policy and procedure The Dishwashing Machine Use policy, revised [DATE], was provided by the DOD on [DATE] at 2:44 p.m. It revealed, in pertinent part, The following guidelines will be followed when dishwashing: wash hands before and after running the dishwashing machine and frequently during the process. Flatware: presoak the flatware, run the flatware through the dishwashing machine in a pallet, wash the flatware in the utensil holder with the eating end pointed upward, wash the flatware in the utensil holder with the handles pointed upward. Presoak dishes or pots that contain dried or burnt food, do not overcrowd racks, use overhead spray to remove loose food particles, after running items through the entire cycle, all to air-dry and clean the dishwashing machine after each meal. C. Observations On [DATE] at 10:10 a.m., during the initial kitchen tour, on the clean side of the dishwasher, there was dried food debris that resembled dried rice. There were also brown and white dried pieces of food and white build-up from water. During a continuous observation on [DATE] beginning at 11:15 a.m. and ended at 1:02 pm. the following was observed: -Cook #1 dumped water off of a lid used to cover the resident's plates. He used the lid to cover a plate that was served to a resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cook #1 had a stack of bowls he was using to serve the chili to the residents. The bowls were visibly wet and had a puddle of water underneath them. -Multiple staff members were using trays to deliver meals to residents in the dining room and eating in their rooms that were visibly wet. On [DATE] at 10:30 a.m. the clean side of the dishwasher remained dirty with dried brown and white food debris. V. Staff interviews The maintenance director (MTD) was interviewed on [DATE] at 10:42 a.m. He said he was responsible for cleaning the ice machine monthly. He said the ice machine should not have mold in it. The DOD was interviewed on [DATE] at 2:33 p.m. He said it was important to label and date all items in the kitchen to ensure the facility was using fresh food. He said if the food expired it could cause a food borne illness. He said the residents at the facility were a high risk population and could contract a food borne illness easily. He said all dining staff members were responsible for labeling and dating all foods in the kitchen. He said the current process in the kitchen was to label foods with the preparation or open date. He said some foods were good for five days or seven days and other foods were good for six months. He said they currently were not labeling foods with use by dates. He said he would provide education to the staff immediately. The DOD said the kitchen should be clean and sanitary at all times. He said the kitchen floor should be cleaned three times per day and should not have a black and orange film on it. The DOD said the maintenance director was responsible for cleaning the ice machine. He said the ice machine should be kept clean and not have mold. The DOD said food should not be stored within the temperature danger zone. He said when a cold item, such as sour cream was served at a meal, it should be stored on ice. He said the sour cream was served to the residents during lunch on [DATE] was in the temperature danger zone, which could have led to foodborne illness. The DOD said dishes should be air dried prior to being stored. He said if dishes had moisture on them it could lead to bacteria and mold growth. He said the clean side of the dishwasher should be cleaned regularly and free from food debris and water build-up.