STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42193 Based on observations, interviews and record review, the facility failed to ensure residents had the right to a dignified existence out of 42 sample residents. The facility failed to ensure residents experienced a dignified living experience by ensuring residents were treated with respect and dignity. Residents of the facility expressed being yelled and chastised by staff and retaliation by the facility. A resident stated he was tired of feeling like we are nobody, he served his country for freedom and he can't die with dignity; he wanted to be treated like a human being, not a child. Furthermore, the facility failed to treat Resident #83 with respect and dignity. Findings include: I. Residents being treated with respect and dignity (cross-reference F565 resident group response) A. Resident group interview The resident group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. The resident in the council meeting said the following: The residents said that dignity and respect had always been a thing around here as residents were always being yelled at and chastised by the staff. One resident said I am tired of the retaliation. When you blow the whistle they retaliate. One of the residents said I am tired of feeling like we are nobody, we are grown adults. The resident then said it makes me wonder why I served my country for freedom and we can't die with dignity. I want to be treated like a human being, not like a child. B. Administrative interview (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 0550 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/20/23 at 5:00 p.m. The DON said the staff treat the residents with respect and dignity. She said when she received a complaint, she would ensure it was investigated to rule out abuse. She said at times the complaint could be customer service oriented, then the staff would be educated on customer service. She said customer service was taught at orientation and it included respect and dignity. Staff were trained to listen to residents and to ensure the resident was cared for in a dignified manner. She said residents had the right to complain and not to be fearful of retaliation. II. Resident #83 A. Resident status Resident # 83, age 81, was admitted to the facility on [DATE]. The April 2023 computerized physicians orders (CPO) indicated that the resident had a diagnosis of chronic obstructive pulmonary disease, insomnia, anxiety disorder, hallucinations, type 2 diabetes and chronic kidney disease. The 3/22/23 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. Resident #83 required supervision with eating, support was provided with showers, however the resident refused each time. The resident required the use of a manual wheelchair. The resident was independent with toilet use, dressing, and bed mobility. B. Observation On 4/19/23 at approximately 1:45 p.m. loud arguing between Resident #83 and the receptionist could be heard. Resident #83 was at the front receptionist desk. The resident was telling the receptionist that she had not done something that he had requested. He was talking loud, using foul language and his tone of voice was argumentative. The receptionist was observed to engage the resident with her tone of voice, was also argumentative and she continued to reply back to the resident in a disrespectful manner. She did not talk to the resident in a manner which provided dignity. C. Resident interview Resident # 83 was interviewed on 4/18/23 at approximately 2:00 p.m. The resident said he did not like how the facility staff spoke to him. He said he had to deal with a lot of issues in his life, but the way he was spoken to by facility staff made him upset. He said the staff would not believe him when he asked for assistance and the request was always matched with an argument from the staff. He said he knew he did not communicate his needs in a pleasant manner. The resident was interviewed a second time on 4/19/23 at approximately 2:45 p.m. The resident said that he felt like his right to be treated with dignity was taken from him. He said that he did not think the receptionist should talk to him the way she did. D. Record review The care plan, revised 1/27/23, included that arguing with Resident # 83 made his situation worse which made him feel like he had been scolded in front of the other residents. The social services (SS) advised the staff for the resident to be spoken to in a calm manner which diffuses a situation. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	E. Staff interviews The DON was interviewed on 4/19/23 at 2:08 p.m. She said Resident #83 had been asking the staff all day about the refrigerator in his room to be repaired. She said Resident #83 told her he felt like he had been disrespected by the staff. Resident #83 spoke of an incident in which he spoke to the receptionist about his refrigerator. He said she told him that it was not her job to look at his refrigerator and that he should go talk to the maintenance department about his problem. Certified nurse aide (CNA) #9 was interviewed on 4/19/23 at 4:00 p.m. The CNA confirmed she observed the interaction between the receptionist and Resident #83. She said that although Resident #83 could be difficult, the receptionist should have walked away when he was using foul language rather than using the disrespectful tone. 48114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48114 Based on observation, record review and interviews, the facility failed to ensure the residents had a right to to be informed of the results or actions taken regarding resident concerns. Specifically, the facility failed to accurately document, demonstrate their response and rationale for complaints, grievances and concerns that were brought up by residents. Findings include: I. Facility policy The Grievance/Concern policy, last revised on 6/1/22, was provided by the DON on 4/25/23 at 12:33 p.m. It read in pertinent part, The patient/resident has the right to voice grievances to the (name) or other agency or entity that hear grievances without discrimination or reprisal and without fear of discrimination or reprisal. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative. Social Services personnel will serve as patient advocates in the grievance/concern process. The Center Executive Director (CED) will service as the Grievance Officer who is responsible for overseeing the grievance process. A description of the procedure for voicing grievances/concerns will be on each unit in prominent location and must include; the right to file grievances orally (meaning spoken) or in writing, the right to file grievances anonymously, the contact information of the grievance official with whom a grievance can be filed, the right to obtain a written decision regarding their grievance; and the contact information of independent entities with whom grievances may be filed. When the grievance/concern is logged, the CED and appropriate department managers will be notified; immediate action will be taken to prevent further potential violations on any patient right while the alleged violation is being investigated. The department manager will; contact the person filing the grievance to acknowledge receipt, investigate the grievance, take corrective actions, if needed, engage the support of the Ombudsman, if warranted, and notify the person filing the grievance of resolution within 72 hours. If the grievance/concern is unable to be resolved satisfactorily, refer the patient/representative to the Market President and/or Market Lead Clinical Specialist for assistance. II. Resident council not being held consistently and privately A. Resident group interview The group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. One resident said staff had postponed their resident council meeting because the facility did not have enough staff. He said the residents went three months without a meeting because not all staff were available and staff kept postponing the meeting. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One resident said staff did not offer a meeting place, so the meetings took place in the main dining room area. One resident said that resident council meetings have never been offered for residents only and staff have always been present every time. B. Resident council minutes The 3/3/23 resident council meeting minutes documented the February 2023 meeting was delayed as not all managers were able to attend. -There was no evidence which showed a resident council meeting was held in February 2023. III. Resident voiced grievances and concerns A. Resident group interview The group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. The residents said when they wrote a grievance the social workers chose which ones they wanted to address. The residents said staff did not want to be bothered by their complaints/grievances and they tried to shut them up. The residents said the social service director (SSD) favorite line was shut up and give us a chance. The residents said staff were not responding to their complaints within 72 hours. One resident said the problem was some residents were afraid to file a complaint/grievance because of retaliation. One resident said he wrote a grievance and never heard anything back from it. One resident said the staff say they would check the grievances and get back to them, but they never get back to them. One resident said that staff met with her, there was no resolution to the problem and was told that was how that staff were. She said she told staff she should not have to put up with their behavior. B. Observation On 4/20/23 at 3:37 p.m. while walking around to the different units with the SSD to check the bulletin boards, grievance forms were not located on the bulletin boards. The process on how to file a grievance was not located on the bulletin boards. The only grievance forms were located outside of the SSD's office. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Interviews The social service director (SSD) was interviewed on 4/20/23 at 3:37 p.m. The SSD said she was responsible for making sure that the bulletin boards down each wing were updated with forms and policies. The social service assistant (SSA) was interviewed on 4/24/23 at 2:40 p.m. The SSA said the social workers were in charge of the grievance process. He said their department dealt with non-medical grievances. The SSA said depending on the complaint the department or individual gets the original copy of the grievance. He said that a grievance was addressed within 72 hours.

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 48114 Based on record review and interviews, the facility failed to provide residents with the opportunity to review their medical records. Specifically, the facility failed to ensure residents were able to access their medical record when requested. Findings include: I. Facility policy The Authorization for Release of Information policy, revised on 5/1/22, by the director of nursing (DON) on 4/25/23 at 5:59 p.m. It read in pertinent part, The company will disclose protected health information (PHI) upon receipt of a valid authorization. Provide access to view all records (including trust fund ledgers, contracts, and other documents between patient and service location) pertaining to a patient to the patient/legal representative as soon as possible and no later than 24 hours of receipt of an oral or written request (excluding weekends and service location holidays). Provide copies of records to patient/legal representative in the form or format requested, if they are readily producible in such form or format, within two (2) working days of a request. The legal representative must complete a written request that shall include the following, or complete a Request and Authorization for Release of Information; a meaningful description of the information to be disclosed, the name of the individual or the name of the person authorized to make the requested disclosure, the name or other identification of the recipient of the information, a description of each purpose of the disclosure (the statement 'at the request of the individual' is sufficient when the individual initiates the authorization and does not or elects not to, provide a statement of the purpose), an expiration date or an expiration event that relates to the individual, and a signature to make health decisions on behalf of the individual and the date. Charging a fee is done at the discretion of the Privacy Officer Designee/Administrator. A reasonable, cost-based fee may be charged for the provision of copies, provided that the fee includes only the cost of; labor for copying the records requested by the individual, whether in paper or electronic form, supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media, postage, when the individual has requested the copy by mailed. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E-mail the Request and Authorization for Release of Information or other written request the Information Regarding Request for Release of Medical Records form and any backup documentation (POA, guardianship, estate paperwork) to (email) If the documents provided require additional involvement by the Law Department an email response should be expected within 48 hours. Otherwise, the service location should produce the records to the requesting party as per the guidelines within this policy. An authorization is not valid if the authorization contains any of the following defects; the expiration date has passed or the event has occurred (information already released in accordance with an authorization), the authorization is missing one or more items of content described above, the authorization is known to have been revoked by the patient or patient's legal representative, the authorization violates a privacy rule standard on conditioning or compound authorizations (the patient was required to sign the authorization in order to receive treatment or the authorization was combined with another document), and material information in the authorization is known to be false by the service location or region, market, area, or corporate department. II. Facility welcome packet The 2023 Welcome Packet read in pertinent part, You have the following rights regarding your medical care: To access all your records and reports, including clinical records (medical records and reports) promptly (on weekdays). III. Resident group interview The group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. One resident said that staff had given him problems when requesting to get his medical records. He said that no staff was able to get his records so he waited for a long time and finally was able to get some of his records but not all of them. Another resident said that staff were against telling him about his medical records. He said that staff have told them that they will get back to them about their records and they never did. A few of the residents said they did not know the process to access their records. IV. Interviews The social service director (SSD) was interviewed on 4/24/23 at 12:16 p.m. The SSD said residents needed to fill out a form in order to request their records. The SSD said the director of nursing (DON) got the records. The SSD said that the minimum data set (MDS) coordinator would help out if needed to get records. She did not know how long the process was to get records out to residents. The SSD said that sometimes the facility had to send for records as all the records were not stored at their facility. She said that records were usually received the next day or two. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The health information manager (HCM) was interviewed on 4/25/23 at 2:15 p.m. The HCM said residents were required to fill out a request for release of records form and put down what dates they wanted. When the form was completed, she said she sent the request form to the corporate office and that corporation determined if they released the records or not. She said that she was not sure if any residents have ever been denied their records. The HCM said that it took 24 hours for approval of records from the corporate office. 20287

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 48114 Based on observations and interviews, the facility failed to ensure residents received notices orally and in writing which included a written description of their legal rights. Specifically, the facility failed to have the required posted information written in a readable font size and placed in an area that had ease of access for the residents. Findings include: I. Resident group interview The group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. Ten out of the 12 residents did not know how to file a complaint with the State Agency department or where to find the information posted. II. Observation On 4/20/23 the legal resident rights were posted in one location at the front of the building on a shelf across from the front desk. The legal rights were put in picture frames printed in small font. There were no postings on each of the units with a list of names, addresses (mailing and email), and telephone numbers of all the pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state laws provide jurisdiction in long-term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. There was nothing posted about how a resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. III. Staff interview The social service director (SSD) was interviewed on 4/20/23 at 3:37 p.m. The SSD said she was responsible for keeping up on the boards and making sure that they were up to date with the appropriate information. The SSD said she did not know that she needed to post information regarding a list of names, addresses (mailing and email), and telephone numbers of all the pertinent State Agencies and advocacy groups. She acknowledged there was no posting of the pertinent information.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 48114 Based on observations, record review and interviews the facility failed to protect the residents rights to provide privacy with mail and packages delivered to the facility. Specifically, the facility failed to ensure residents were provided privacy when receiving and opening personal packages. Findings include: I. Facility Policy The Patient/Resident Mail Delivery policy, last revised on 4/1/18, received from the director of nurses on 4/25/23 at 12:33 p.m. read in pertinent part, patients/residents/guests have the right to privacy in written communications, to send and promptly receive unopened mail and other letters, packages, and other material delivered to the facility for the patient/resident/guest, including those delivered through a means other than a postal service. The recreation director or designee will: -Coordinate patient/resident mail delivery. -Ensure that mail is delivered to the person unopened or postmarked or postmarked (for outing mail) within 24 hours, including Saturday. II. Facility welcome packet The 2023 Welcome Packet read in pertinent part, You have the following rights:To have privacy in sending and getting mail and emails. III. Resident group interview The resident group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. One resident said that the activity staff made him open his package in front of them. The resident said that he received some generic vitamins and was told from the activity staff that they had to take them from him. The resident said he was pretty upset that they would not allow him to have my vitamins. Two other residents verified that the activity staff member had made the resident open his package in front of them and took his vitamins. Another resident said when he first arrived at the facility his social security mail was open, so he took his mail, went and talked to the administrator and told them that he would not tolerate this. One of the residents said the business office took the mail, held onto the mail, screened the mail, and forced the residents to open our packages in front of them. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The residents said they have been told they did not get mail on Saturday. They said sometimes it was delivered and sometimes it was not. IV. Staff Interviews The activity director (AD) was interviewed on 4/24/23 at 2:45 p.m. The AD said the business office got the mail, they sorted it out and gave the resident mail to the activities department. She said once the mail had been sorted out that they delivered the mail the same day. She said she had never had any issues with residents having concerns about their mail being opened up. The AD was interviewed again on 4/24/23 at 4:10 p.m. The AD said they were allowed to know what was in the packages the residents receive. The AD said if the resident gets medicine and if it was something they should not be taking then it became a safety issue. She said the activity staff asked the residents to open the package in front of them, but if they say no she said they walk out and advise the nurse that they received a package. The AD said having the residents open their packages in front of them was not a violation of privacy. The AD said if the residents got medications the activity staff would take them and take it to the senior director or social worker. The business office manager (BOM) was interviewed on 4/24/23 at 5:43 p.m. The BOM said she had retrieved the mail from the conference room closet. She said it was Saturdays (4/22/23) mail. She said the mail was placed in the closet and then it was sorted, she said there was no staff available to separate the mail between resident and facility mail on Saturdays, so it was held back and delivered on Monday. The director of nurses (DON) was interviewed on 4/24/23 at 6:30 p.m. The DON acknowledged the previous nursing home administrator had put into effect, when a package was delivered to a resident then the package had to be opened in front of the activity associate. The reason was because she wanted to ensure no medications were being delivered.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48114 Based on observation and interviews, the facility failed to ensure that each resident had the right to examine the results of the most recent Federal survey of the facility conducted by the Federal or State surveyors and any plan of correction in effect with respect to the facility. Specifically, the facility failed to: -Have a posting in a prominent location of where the survey results were kept; and, -Have three years of survey results available to view. Findings include: I. Facility welcome packet The 2023 Welcome Packet read in pertinent part, You have the following rights: To review the nursing home's health and fire safety inspection results. II. Resident group interview The group interview was conducted on 4/20/23 at 11:00 a.m., with 12 alert and oriented residents. The residents said they were not aware they could view the Federal/State survey results. The residents said they were not aware of any location and they had not been told of the results of the survey. They said they would be interested in reading the results of the surveys. III. Observations On 4/20/23 at 3:37 p.m., the facility did not have the posting notification of the availability of survey reports in areas of the facility that were prominent and accessible to the public. At 4:05 p.m., the survey binder was located on top of a table behind the front desk. The survey binder was not up to date, as it did not have the past three years of surveys in it and the corrections of the findings. The survey binder had the survey results from 8/31/21, 9/2/21, 6/1/22, 10/20/22, and 12/28/22. -However, the binder was missing11 additional surveys. The following surveys which were completed within the last three years which were not included in the binder were: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-4/20/2020; -9/9/2020; -12/15/2020; -1/20/21; -5/17/21; -7/8/21; -7/23/21 life safety; -2/9/22; -8/2/22; -8/23/22; and, -11/8/22 life safety. IV. Interviews The social service director (SSD) was interviewed on 4/20/23 at 3:55 p.m. The SSD did not know where the binder of past inspections were kept and had to ask the director of nursing (DON). The director of nursing (DON) was interviewed on 4/20/23 at 4:00 p.m. The DON said the survey binder was kept up front. The DON said the previous nursing home administrator had viewed the binder last. The survey book was not up to date, as it did not have the past three years of complaint investigations. The survey book was missing the plan of corrections for the surveys.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024 Based on observation and interviews, the facility failed to provide a homelike environment for residents on six of six hallways and common areas. Specifically, the facility failed to inform and encourage residents and their families to decorate resident rooms with personal belongings to make it homelike. Findings include: I. Observations Resident rooms Multiple resident rooms throughout the facility on 4/17/23 had no homelike or personalized decorations. The walls were bare or had a facility style picture, nothing personalized. -room [ROOM NUMBER] had no homelike or personalized decorations. -room [ROOM NUMBER] had no homelike or personalized decorations. -room [ROOM NUMBER] had no homelike or personalized decorations. -room [ROOM NUMBER] had no homelike or personalized decorations. -room [ROOM NUMBER]B had no homelike or personalized decorations. -room [ROOM NUMBER]B had no homelike or personalized decorations. -room [ROOM NUMBER] B had no decorations or personalized decoration. -room [ROOM NUMBER]B had no homelike or personalized decorations. -room [ROOM NUMBER]A had no homelike or personalized decorations. -room [ROOM NUMBER] was observed on 4/17/23 at 10:30 a.m. The resident's room was to be plain and bare. There were no pictures on the wall and had no family photos. The resident's room did not look like anyone was living there and was not homelike. -room [ROOM NUMBER] a was observed on 4/19/23 at 9:52 a.m. The resident's room had no personal items (no pictures or decor in the room). II. Resident representative interview (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11's representative was interviewed on 4/20/23 at 5:03 p.m. She stated that no staff told her her father could have personal belongings in his room. III. Staff interviews Registered nurse (RN) #1 was interviewed on 4/24/23 at 11:00 a.m. The nurse said the residents could have decorations in their rooms, that was their choice. She said the social services department should inform residents and family members they could bring personalized belongings in for the residents' rooms. RN #2 was interviewed on 4/24/23 at 11:00 a.m. She said residents could choose to decorate their rooms and that it was their choice if they wanted stuff in their rooms. The social worker (SW) was interviewed on 4/24/23 at 11:40 a.m. The SW stated that residents were allowed to have their own personal items in their rooms. She said she told the families to not bring in valuables. The SW stated the family brought in a television for Resident #11.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on record review, observations and interviews the facility failed to develop and implement a comprehensive, resident centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for one (#16) out of 42 sample residents. Specifically, the facility did not ensure Resident #16's comprehensive care plans were developed and included his discharge planning and goals. Findings include: I. Resident #16 A. Resident status Resident #16, age 60, was admitted [DATE]. According to the April 2023 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, history of traumatic brain injury, mild neurogenic disorder, seizures and schizophrenia. According to the minimum data set (MDS) assessment on 2/10/23, the resident did not participate in assessment and goal setting, and the overall discharge expectation was coded as unknown or uncertain. B. Resident interviews Resident #16 was interviewed on 4/19/23 at 12:00 p.m. The resident stated he would like to get into an assisted living setting. The resident said he had been treated like a teenager and wanted a place that had more privacy. Resident #16 said he had not spoken with the social services department about his desired goal for discharge to an assisted living setting. C. Record review The care plan was initiated on 2/3/23. However, the care plan did not indicate stated goals and objectives of Resident #16. First documented note from social services department was on 2/6/23, which documented that Resident #16 refused a copy of the care plan. -The care plan continued to not include his discharge plans or goals. II. Staff interview The social services director (SSD) was interviewed on 4/20/23 at 10:00 a.m. She was not aware Resident #16 was interested in moving to an assisted living setting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/24/23 at 4:45 p.m. The DON said that care plans should be updated in a timely manner. The social worker then reviewed with the resident and family.

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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 0676 Level of Harm - Actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024 Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services to maintain or improve residents' ability to perform activities of daily living (ADLs) for two (#8 and #11) out of three reviewed for ADLs out of 42 sample residents. Resident #8 admitted to the facility for long term care with diagnoses of cerebral palsy (disorders that affect a person's ability to move and maintain balance and posture), legal blindness, paraplegia (paralysis of the lower body), reduced mobility, lack of coordination, major and depressive disorder.The resident required extensive two person assistance with most ADLs. The resident had used an electric wheelchair for independence and mobility since she was four years old. The facility failed to repair the resident's electric wheelchair which prevented her from getting out of bed, attending activities and the ability to socialize with staff and other residents (cross-reference F679 for activites). The resident stated due to not being able to use her electric wheelchair, it has been death to me and said they (the facility) took my legs away. I can't leave my room. She said the facility did not feel like her home anymore. Per staff interviews, the resident was not herself and upset since she was unable to get out of her room due to not having her electric wheelchair. In addition, the facility failed to ensure strategies were in place to effectively communicate with Resident #11, who spoke a language other than English and assess Resident #11's wheelchair and ambulation to maintain his mobility. Findings include: I. Resident #8 A. Resident status Resident #8, under age 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the April 2023 computerized physician orders (CPO) diagnoses included cerebral palsy, legal blindness, reduced mobility, lack of coordination, major depressive disorder, personality disorder, generalized anxiety disorder, stiffness of joints, muscle weakness, contractures of left elbow, right elbow, left wrist, and right wrist, complete paraplegia and history of diseases of the musculoskeletal system and connective tissue. The 3/29/23 minimum data set (MDS) assessment documented the resident had a minor cognitive deficit with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive two person assistance with bed mobility, transfers, dressing, toileting, extensive one person assistance with personal hygiene and set up assistance for eating. The resident used an electric wheelchair. B. Resident interview and observation (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	The resident was interviewed on 4/17/23 at 4:47 p.m. The resident said her personalized electric wheelchair was broken. The tray that was used for her to do activities was broken. She said a certified nurse aide (CNA) broke the tray by letting it slam to the floor rather than letting it go slowly. She said her electric wheel chair which she used for mobility would not turn on. The resident said the wheelchair had been broken for approximately five weeks. She said she had written a letter to administration to inform them the wheelchair was broken and it still had not been fixed. The resident said she had been using an electric wheelchair since the age of four years old. She said she could not use a manual chair. The resident was interviewed a second time on 4/18/23 at 2:58 p.m. The resident said the electric wheelchair had been working on her birthday and three days later it stopped working. The resident said she had been sitting in the wheelchair in the room and attempted to turn it on to move into position to get into bed and it would not turn on and it had not worked since. She said a few days after it had stopped working she had asked a CNA to check the chair to see if it would work and it would not. She said that neither staff or administration had informed her about either a new chair or fixing the current one. She said she started using an electric wheelchair at age four and that was all she had ever known, she said using a manual wheelchair would be like death to me. She said she would have to depend on everyone to move her in the chair. She felt the facility had dehumanized her by not fixing the wheelchair, they took my legs away. I can't leave my room. During the interview at 3:08 p.m. the resident called a family member. The family member said the facility staff have not been nice at all and she felt she had to stay away and could not visit the resident. She said the facility informed her they would have to pay out of pocket to get the wheelchair fixed or a new one and the facility had not offered any assistance, they are not helping at all. She said the resident had been praying to die and the resident had been suffering mental anguish because the wheelchair was not working. As a result of the wheel chair not working, the resident has had to stay in bed, otherwise, she was always up and about. The resident said she felt the facility was not a home anymore. The resident was interviewed a third time on 4/19/23 at 10:16 a.m. She said that her family member had the wheelchair company and had been informed there had been appointments scheduled to come inspect the wheelchair to see what would be needed to fix it and that the appointments had been canceled by the facility. She had been informed that she was qualified for new parts that would fix the chair. She said this information makes her feel like they kept her in bed on purpose when they did not need to. During the survey from 4/17/23 to 4/24/23 the resident did not leave her bed. C. Record review Care plan The care plan for daily routine, revised on 10/24/22, documented the resident indicated it was important that she had the opportunity to engage in daily routines that are meaningful to her. Interventions include it was important for her to be able to choose her bedtime, watching tv (television), and to engage in her favorite activities. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	The care plan for psychosocial distress, revised on 10/24/23, documented the resident exhibited psychosocial distress with her own well-being. Interventions include: monitor mood state or behavioral symptoms impacting social relationships, encourage resident participation in activity preferences, encourage the resident to notify and seek out staff support as indicated for support and intervention. The care plan for distressed mood, revised on 2/7/22, documented the resident is at risk for distressed/fluctuating mood symptoms related to sadness/depression. The resident may exhibit depressed mood through mood swings, self-isolation, less talkative increased tearfulness, increased sleep, decreased appetite, and repeatedly going over thoughts. Interventions include: monitor for signs/symptoms of worsening sadness/depression, social services to provide support as needed. Progress notes An encounter with the physician note dated 2/3/23, documented a persistence of depression and the tray and wheelchair being broken again, stuck in the reclined position, thus being confined to her bed and not happy. She said that her mood sucks, often has low energy and is getting worse. The resident said she has severe anxiety and a main source of was due to isolation. She said she tries to stay busy by hanging out with other residents. She said she was unable to do art because the tray for the wheelchair was broken and would take six months to replace, she had tried to do some art but was unsuccessful. A social services note dated 2/10/23 documented a phone call with a wheelchair company regarding the expense to fix the electric wheelchair. A social services note dated 2/22/23 documented social services communication with the insurance company regarding lack of funds to repair the electric wheelchair. Nursing note dated 3/3/23 documented the resident had been up in her electric wheelchair and participating in activities that day. -The wheelchair was running due to the maintenance director wrapping the joystick (see director of nursing interview), however the wheelchair was still not functioning properly. A social services note dated 3/31/23 documented a phone call with a care coordinator regarding the expense to fix the broken electric wheelchair. Interdisciplinary team (IDT) note dated 4/5/23 documented the resident's electric wheelchair was not working and therapy had been working with the wheelchair company for maintenance and the resident potentially needs a new wheelchair. A nursing note dated 4/10/23 documented the residents refusal to use a manual wheelchair because they were ill fitting, caused pain, and she would be unable to move herself, requiring another person to move her. A general note dated 4/11/23 documented the electric wheelchair was broken and then reported the resident being frustrated with the chair being broken and she was unwilling to use a manual wheelchair due to being uncomfortable and the resident was in bed during the visit. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	D. Wheelchair company interview and documentation The director of the wheelchair company was interviewed over the phone on 4/24/23 at 1:14 p.m. He said he was the director for the area. He remembered speaking to the family member. He said once a wheelchair was paid for by Medicaid it stayed covered by them. He said he had informed the family member that appointments had been scheduled visits but did not know why they had been canceled. The director delivered documentation for 10/19/22 that revealed, an order for repairs was created but canceled later the same day. The facility manager called and wanted to process an order for a new chair, the repair order was canceled and forwarded to another department. On 10/19/22 the rehabilitation department of the wheelchair company received a call from the facility to start an order for a new chair, they were informed that Medicaid did not pay for a new wheelchair in a skilled nursing facility, the order was canceled on 10/31/22. No further contact had been established since 10/31/22. -The facility did not contact the wheelchair company to establish a repair order again. E. Staff interviews Registered nurse (RN) #1 was interviewed on 4/19/23 at 10:44 a.m. She said the resident would rather have the electric wheelchair than any other one, she would not be able to use a manual wheelchair, someone would have to move her. The RN said the resident would visit a lot and go eat in the dining room, she said now she could not do those things. RN #2 was interviewed on 4/19/23 at 10:44 a.m. The RN said the resident used to be all over the place in the electric wheelchair since she loved to get out. The activities director (AD) was interviewed on 4/19/23 at 12:40 p.m. The AD said the resident liked to get out and do activities. She said the resident and another resident enjoyed having a book club and that she was very social and enjoyed visiting people in the building. The AD said the resident liked being in her room sitting in the chair listening to music, watching tv and playing solitary type games on the tv. The AD said the resident was upset about the wheelchair being broken. The DON was interviewed on 4/19/23 at 2:00 p.m. The DON said the tray and the wheelchair were broken and have been for a few months. The DON said the resident could fill out a grievance form if something was broken. The DON said the previous maintenance director had wrapped the joy stick, the controller of the wheelchair, to keep it working. The DON said the therapy department would be the contact for the wheelchair company not the social services department. She said they have attempted to have it fixed but did not explain how. 48114 II. Resident #11 A. Resident status (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Resident #11, age 89, was admitted on [DATE]. According to the April 2023 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease and other intervertebral disc degeneration, lumbar region. The 2/20/23 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of zero out of 15. He required extensive assistance with dressing, toilet use, and personal hygiene. He used a wheelchair and walker for mobility. Hospice care was coded. No therapy or restorative nursing minutes were coded. B. Resident observations On 4/17/23 at 12:10 p.m. Resident #11 sitting in an oversized wheelchair in the dining room. C. Resident interview and representative interview On 4/19/23 at 1:36 p.m. Resident #11 was interviewed and he shook his head up and down when asked how he was doing. Resident #11 had difficulty understanding what was asked due to a language barrier. Resident #11's daughter was interviewed by phone on 4/20/23 at 5:03 p.m. She said her father spoke little English. She said the facility had a language line for him and staff should be using it to communicate with him. She said that she asked for physical therapy (PT) for her father and the facility told her that when they ask him to participate in PT he always says no. She said she had been told they could not force him to do PT. She said to the facility if they could encourage him to go and they told her no. The daughter said that Resident #11's wheelchair was issued from the facility. She said he had a walker in his room and should be using it. She he had a regular cane and the facility took the cane away from him. She said that her father was prone to falling and needed assistance. D. Record review The care plan, dated 4/17/23, documented that Resident #11 had communication challenges secondary to speaking a foreign language. Interventions documented: to provide Resident #11 with a translator to aid in communications. The care plan, revised on 4/22/21, indicated Resident #11 had impaired communication as evidenced by language barrier. His primary language is Cantonese. Interventions documented: interpreter as needed. Refer to Speech Therapy for screening as appropriate. Encourage the resident/patient to speak slowly. Encourage and validate meaning or nonverbal communication. Break tasks down into smaller steps. Allow sufficient time for the resident/patient to process and respond. Give one direction at a time or ask one question at a time and repeat directions. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	The care plan, revised on 10/4/22, indicated Resident #11 required assistance for ADL in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to limited mobility, dementia, frailty. Interventions documented: provide resident supervision set up assistance with ADLs, may need one person assist at times especially with toileting and grooming. He walks with a walker. Monitor for decline in ADL function. Refer to rehabilitation therapy if decline in ADLs is noted. Provide cueing for safety and sequencing to maximize current level of function. Arrange resident/patient environment as much as possible to facilitate ADL performance as indicated. Provide resident set-up supervision assist for bed mobility. E. Interviews Certified nurse aide #2 (CNA) was interviewed on 4/23/23 at 9:30 p.m. CNA #2 said he had never used the language line to communicate with Resident #11. Licensed practical nurse #3 (LPN) was interviewed on 4/23/23 at 9:35 p.m. LPN #3 said that Resident #11 did not understand much and he was not very verbal. LPN #3 said that no staff had used the language line and was not sure if they had a language line. LPN #3 was not able to find where the language line information was kept. The social service director (SSD) was interviewed on 4/24/23 at 11:40 a.m. The SSD said she contacted the family first and asked what the resident was able to understand. She said the language line had been downloaded onto tablets. She said the chaplain was going to get someone to interpret, but had not happened. The SSD said Resident #11 would point at things to get his point across. She said she had a picture book for him and he stated, I talk and did not like the pictures. She said he was the first resident the facility have had communication issues with. She said she was not sure how much he understood or what the staff were asking. She said he was more verbal with things he liked. The SSD was unable to pull up the language line on her tablet. The social service assistant (SSA) was interviewed on 4/24/23 at 12:00 p.m. He said the language line software was easy to use and was able to pull up the information. The SSA said all staff had access to either video chat or phone chat in the preferred language needed. He said staff had not been trained on how to use the language line. Licensed practical nurse (LPN) #1 was interviewed on 4/24/23 at 12:09 p.m. LPN #1 said she had never used the tablet to communicate with Resident #11. LPN #1 pulled a tablet out from behind the nurses station and was able to log in. LPN #1 said she would ask yes or no questions with Resident #11. Certified nurse aide (CNA) #4 was interviewed on 4/24/23 at 12:25 p.m. CNA #4 said that she used simple words in order to communicate with Resident #11. CNA #4 said she had never had a full conversation with Resident #11. The director of rehabilitation (DOR) was interviewed on 4/24/23 at 7:00 p.m. She said Resident #11's wheelchair was 20 inches and was too big for him. She said she would send additional information about Resident #11's wheelchair. -However, no documentation was provided before exit on 4/24/23.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record reviews, and interviews, the facility failed to ensure that four (#68, #83, #13 and #42) out of six reviewed for activities of daily living received services to maintain grooming, personal and oral hygiene out of 42 sample residents. Specifically, the facility failed to ensure: -Resident #68 and Resident #83 received showers; and, -Resident #42 and #13 received nail care. Findings include: I. Facility policy The Activities of Daily Living (ADL) policy, revised 6/1/21, was received from the director of nursing (DON) on 4/24/23. The ADL policy read in part, a resident who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. II. Failure to meet receive showers A. Resident #68 1. Resident status Resident #68, age 62, was admitted [DATE]. According to the April, 2023 computerized physician orders (CPO), medical diagnoses include chronic obstructive pulmonary disease (COPD), paranoid schizophrenia, type 2 diabetes, chronic kidney disease, muscle weakness, and abnormal gait and mobility. The 4/3/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a score of 10 out of 15 for the brief interview for mental status (BIMS). The resident required two plus person physical assistance for transfer and mobility, and one person assistance for bathing. The MDS assessment showed the resident had no behavior problems and did not refuse care. 2. Resident interview The resident was interviewed on 4/17/23 at 2:25 p.m. The resident said that he had not had a shower for weeks. He said that he wanted to have his two showers a week. The resident was interviewed a second time on 4/18/23 at approximately 11:15 a.m. The resident said he had not been offered a shower. He said he had not refused any showers. 3. Record review (continued on next page)

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Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, revised on 11/14/22, identified the resident was at risk to perform activities of daily living (ADLs). The care plan documented he often would decline showers on his preferred shower days. -Intervention category of the care plan did not indicate any plan for when he refused to shower. Progress notes reviewed from 3/1/23 through 4/24/23 did not include documentation regarding any shower refusals. One nursing note on 3/29/23 noted that Resident #68 refused to shower on that date. The Weekly Bath and Shower Report and Master Bathing list received from DON on 4/20/23 for Resident #68 showed the resident was scheduled for bathing once weekly on Wednesdays. Per weekly bath report, Resident #68 refused bathing every week from 3/8/23 through 4/19/23, for the past seven weeks. -The medical record had only one nursing note on 3/29/23 which documented Resident #68 refused to shower on that date. There were no additional progress notes when the resident refused over seven weeks. 4. Interviews Certified nurse aide (CNA) #1 was interviewed on 4/20/23 at 2:30 p.m. CNA #1 said Resident #68 required assistance most of the time with activities of daily living, which included showers. CNA #1 said Resident #68 usually refused his showers. CNA #1 said the process when a resident refused to shower, the licensed nurse for the unit needed to be notified. The licensed nurse would then speak to the resident and have another CNA go in the resident's room to offer a shower. She said the resident was asked multiple times (at least three) per day to shower. The DON was interviewed on 4/24/23 at 4:45pm. The DON said when a resident refused a shower, the CNAs approached the resident again. If the resident still refused, the CNA asked the licensed nurse to assist. The nurse verified and then asked the resident again about showering. The DON said that if the resident refused to shower three times in a row, social services was notified by staff. The social services director (SSD) was interviewed on 4/24/23 at 6:00 p.m. The SSD said the social service assistant was responsible for going back to talk with CNAs and the resident for any resident issues. She stated she found out at the beginning of April 2023 that Resident #68 was not receiving his showers. The SSD did not identify any interventions or approaches used by the social work team to achieve showers being completed for this resident. 48114 III. Fingernails not maintained A. Resident #42 1. Resident status (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #42, age 72, was admitted on [DATE]. According to the March 2023 computerized physician orders (CPO), the diagnoses included anoxic brain damage, not elsewhere classified. The 3/10/23 minimum data set (MDS) assessment revealed the resident had a moderate impairment with a brief interview for mental status score of nine out of 15. He required extensive assistance with bed mobility, transfer, locomotion on and off unit, dressing, toilet use and personal hygiene. The resident refused to bathe, get dressed or get out of bed. 2. Observation On 4/18/23 at 5:18 p.m., an unidentified CNA served the dinner meal to Resident # 42. The CNA put a sanitizing wipe on his lap. However, the resident did not use it and no staff helped him. He then began to eat his meal. The resident nails were visibly soiled with dark matter under his fingernails. On 4/19/23 at approximately 9:00 a.m., the resident was lying in bed. His breakfast tray was on a bedside table. The resident's nails and nail beds had a dark substance under the nails and around the nail bed of his fingers bilaterally. The resident's nails were approximately half an inch over his nail bed. At 4:30 p.m. Resident #42's fingernails had dark brown matter under his fingernails. At 4:40 p.m., the licensed practical nurse (LPN #2) sat next to Resident #42 and explained to him that she was going to cut his fingernails. Resident #42 was calm and cooperative as the LPN cut and filed down his fingernails. 3. Record review The care plan, revised on 3/24/23, identified the resident required dependent of one (staff) for activities of daily living (ADL). The resident was dependent on staff with bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to limited mobility, and behavioral symptoms. Pertinent interventions included, attempt to have male staff provide care when the resident was resistant with other staff. Communicate what you are doing with resident prior to providing care; allow resident time to process to prevent frustration. The care plan, revised on 12/12/22, documented that Resident #42 exhibits, or has the potential to exhibit physical behaviors related to history of harm to others; kicking and punching staff while attempting to perform basic needs for resident. Interventions documented explain all care, including procedures (one-step at a time), and the reason for performing the care before initiating. -Although the resident had a care plan for refusal of care, the resident let the nurse cut his nails (see observation above). 4. Interview (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 was interviewed on 4/19/23 at 4:36 p.m. LPN #2 said the best time to cut residents ' fingernails was during or after showers. She said resident nails should be cut when needed. She said the resident had refused to have his nails cut in the past, but would then need to be re-approached. LPN #2 said his fingernails were long and dirty and needed to be cut. B. Resident #13 1. Resident status Resident #13, age less than 65, was admitted on [DATE]. According to the April 2023 CPO, the diagnoses included epilepsy, unspecified, cognitive communication deficit and muscle weakness and lack of coordination. The 1/27/23 MDS assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status score of 12 out of 15. He required supervision with personal hygiene as he has a history of declining to shower. 2. Resident interview and observation The resident was interviewed on 4/18/23 at approximately 3:00 p.m. The resident said that he needed help to clip his nails. He said he had requested from the staff, but had not received assistance. The resident's nails on both of his hands were approximately half of an inch over his nail bed. On 4/19/23 at 4:49 p.m., registered nurse (RN) #1 observed the resident's nails and acknowledged they needed to be cut, as they were long. Resident #13 was interviewed again on 4/20/23 at approximately 10:00 a.m. The resident said his nails were clipped and cleaned last night. He said they feel much better. 3. Record review The care plan, revised on 1/3/23, identified Resident #13 was at risk for decreased ability to perform ADL(s) related weakness, and debility. Pertinent interventions included: required one-person assist with ADLs, may need supervision set up. 4. Interview RN #1 was interviewed on 4/19/23 at 4:49 p.m. RN #1 said the best time to cut a resident's fingernails was during their shower times. She stated fingernails should be looked at once a week. She acknowledged after observing Resident #13 fingernails, they need to be cut and cleaned up.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024 Based on observations, interview and record review, the facility failed to provide activities that meet the interests and choices of residents for one resident (#8) of three residents reviewed for activites out of 42 sample residents. Specifically, the facility failed to provide activities and interactions for Resident #8. Findings include: I. Resident #8 A. Resident status Resident #8, under age 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the April 2023 computerized physician orders (CPO) the diagnoses include cerebral palsy (disorders that affect a person's ability to move and maintain balance and posture), legal blindness, reduced mobility, lack of coordination, major depressive disorder, personality disorder, generalized anxiety disorder, stiffness of joints, muscle weakness, contractures of left elbow, right elbow, left wrist, and right wrist, complete paraplegia (paralysis of lower body), and history of diseases of the musculoskeletal system and connective tissue. The 3/29/23 minimum data set (MDS) assessment documented the resident had a minor cognitive deficit with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive two person assistance with bed mobility, transfers, dressing, toileting, extensive one person assistance with personal hygiene and set up assistance for eating. B. Resident interview and observations (cross-reference F676 for activities of daily living) The resident was interviewed on 4/17/23 at 4:47 p.m. The resident said her electric wheelchair was broken. The tray that she used to do activities was broken. She said a certified nurse assistant (CNA) broke the tray by letting it slam to the floor rather than letting it go slowly. Observation of the resident's room indicated that the resident enjoyed coloring and other activities. The resident was in bed and the wheelchair was not in use and had a large amount of wrapping around the joystick activator. The resident was interviewed on 4/18/23 at 2:58 p.m. The resident said she could not do activities or leave the room because of the wheelchair not working. The resident said she felt the facility was not a home anymore (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was interviewed on 4/19/23 at 10:16 a.m. She said since her wheelchair was broken she was unable to go to karaoke, poker, or Uno (card game). She said she used to go on the facility outings including a bowling trip. She said she had all kinds of papers to color in the closet but could not color them because she did not have the tray on her wheelchair. She said she felt the facility kept her in the bed on purpose. She said she did not get to see friends anymore because she did not get out of bed due to not having her wheelchair. The resident said she had depression and she was trying to keep it from getting worse but the longer she laid in bed the worse it got. The resident had one visitor other than providers and the resident was unable to leave the room for activities or dining during the survey 4/17/23 to 4/24/23. C. Record review The care plan for activities, revised on 10/24/22, documented that it was important for the resident that she have the opportunity to engage in activities, she liked to play games, to color, attend resident council, and be aware of facility happenings. Goals included the resident will continue to attend groups or activities of her interest. Interventions include: initiate interactions with the resident and welcome ideas for the activities department including outing choices and provide pictures to color as requested or as needed. The care plan for a lap tray, revised on 10/24/22, documented the resident utilizes a lap tray for safety but also for diversional activities, meals, and sensory integration due to weak core muscle strength related to cerebral palsy diagnosis. Interventions include: the lap tray will be used for recreational activities and meals as resident desires, and the resident is alert and oriented times three and decides when she wants to take the lap tray off. The care plan for patient interaction/engagement, revised on 10/24/22, documented the resident saying it was important that she has the opportunity to engage in daily routines that are meaningful relative to her preferences. Interventions include: the importance of engaging in favorite activities. Progress notes A social services note dated 2/10/23 documented a phone call with a wheelchair company regarding the expense to fix the electric wheelchair. A social services note dated 3/31/23 documented a phone call with a care coordinator regarding the expense to fix the broken electric wheelchair. The interdisciplinary team (IDT) note dated 4/5/23 documented the resident's electric wheelchair was not working. An IDT note dated 4/5/23 documented the wheelchair was not working. A nursing note dated 4/10/23 documented the residents refusal to use a manual wheelchair because they were ill fitting, caused pain, and she would be unable to move herself, requiring another person to move her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A general note dated 4/11/23 documented the electric wheelchair was broken and then reported the resident being frustrated with the chair being broken and she is unwilling to use a manual wheelchair due to being uncomfortable. D. Staff interviews Registered nurse (RN) #1 was interviewed on 4/19/23 at 10:44 a.m. The RN said the resident's wheelchair was broken. She was unaware if the facility had done anything to fix it and the resident would not be able to use a manual wheelchair, someone would have to move her. The nurse said the resident used to visit a lot and would go eat in the dining room, but she could not now. RN #2 was interviewed on 4/19/23 at 10:44 a.m The nurse said the resident used to be all over the place in her wheelchair and she loved to get out of her room. The activities director (AD) was interviewed on 4/19/23 at 12:40 p.m. The AD said the resident liked to get out and do activities. She said the resident and another resident enjoyed having a book club and that she was very social and enjoyed visiting people in the building. The AD said the resident liked being in her room sitting in the electric wheelchair listening to music, watching television , and playing solitaire type games on the television. The AD said the resident was upset about the wheelchair being broken. The AD acknowledged they did not consider a one-to-one activities program for the resident since she was not able to attend activities. The activities assistant (AA) #1 was interviewed on 4/19/23 at 12:44 p.m. AA #1 said she had not gone in to see the resident in the last two days. The director of nursing (DON) was interviewed on 4/19/23 at 2:00 p.m. The DON said the tray and the wheelchair were broken and have been for a few months. The DON said the resident could fill out a grievance form if something was broken. The DON said the previous maintenance director had wrapped the joy stick, the controller of the wheelchair, to keep it working.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, interviews, and record review, the facility failed to ensure that two (#6 and #19) residents out of 42 sample residents, received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #6 and Resident #19. Findings include: I. Facility policy The Memory Support Program Policy for Staff Education and Training, revised 5/1/22, was provided by the director of nursing (DON) on 4/26/23 at 9:29 a.m. It read in pertinent part: -All direct care staff assigned to the Memory Support Program as well as ancillary staff and volunteers, receive orientation to the Memory Support Program. -In-service training programs are conducted monthly for program staff -Dementia education covered modules: Module 1, Understanding the world of dementia, the person and the disease, Module 2, Being with a person with dementia, listening and speaking, and Module 3, Being with a person with dementia, actions and reactions -The purpose of the Hand-in-Hand training is to provide nursing homes with a high quality training that emphasizes person-centered care in the care of persons with dementia. II. Resident #6 A. Resident status Resident #6, age 69, was admitted [DATE]. According to the April 2023 computerized physician orders (CPO), diagnoses included cognitive communication deficit, dementia, legal blindness, diabetes, chronic obstructive pulmonary disease and morbid obesity. The 2/8/23 minimum data set (MDS) assessment documented moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of fifteen. The resident had behavioral symptoms not directed toward others (vocal, screaming) that interfered with the resident participation in activities or social interactions, and intruded on the privacy or activity of others, and disrupted care. The behaviors were unchanged from behavior status from the prior assessments. The resident ' s functional status of two plus person assist for transfer, dependence for eating, hygiene and showering. According to her activity preference assessment she liked listening to music s and participating in religious services or practices were very important to her. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview On 4/17/23 at approximately 10:00 a.m., the resident was attempted to be interviewed. The resident yelled out help from her room. The resident was unable to answer any questions, as she kept repeating she needed help, although could not describe what type of help was needed. The call light was on the floor out of reach. C Observations and interview 4/17/23 -At 10:05 a.m., the resident was in her room yelling out help. She was lying in bed. 4/18/23 -At 3:33 p.m, Resident #6 was sitting up in a chair, observed to be yelling help at least five times over one minute. The resident was quiet and calmly conversing immediately after a certified nurse aide (CNA) entered the room. When the CNA left the room, Resident #6 yelled for help again. Resident #16, who was in his room, which was directly across the hallway from Resident #6, yelled shut up, toward the room of Resident #6. -At 3:48 p.m., the resident continued to yell for help. She was lying in bed. -At 4:19 p.m., the resident continued to yell from bed help. 4/19/23 -At 9:06 a.m., the resident was sitting in chair, and continued to yell for help. -At 9:50 a.m., the resident continued to yell for help, staff passed by the room while the resident was yelling. -At 10:06 a.m., the resident continued to yell for help. -At 2:00 p.m., the resident was lying in bed, and continued to yell for help. -At 2:45 p.m., the resident was lying in bed, continued to yell for help, and a staff member passed by the room without stopping. -At 4:56 p.m., door was closed and the resident continued to yell for help. -At 5:19 p.m., door was open, CNA #1 entered the room, and the resident then was talking calmly with staff about her family. 4/20/23 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 2:24 p.m., the resident was calling out from bed, help me with foul language. No staff were observed to enter her room to check to see what type of help she needed. At 2:40 p.m., licensed nurse (LPN) #5 said the resident had a dry mouth and that she wanted to see if she could get an order for Biotene (dry mouth rinse). She said that could be part of the problem with her hollering out. -At 2:52 p.m., the resident was calling out continuously. 4/24/23 -At 10:15 a.m., the door was open, the resident was in bed, yelled for help over a five minute period, and staff did not respond to the room. -At 11:51 a.m., resident yelled for help every one to two minutes over a five minute period, with no staff response to the room. -At 1:30 p.m., resident was lying in bed, continued to yell for help. D. Record review The April 2023 CPO showed the following medications were ordered: -Seroquel 50 mg (milligrams) by mouth three times daily, for visual hallucinations/dementia, with a start date 4/19/23; and, -Trazodone 50 mg by mouth at bedtime for vascular dementia, with a start date of 4/10/23. The care plan, last updated on 2/28/23, identified problems with self- management due to dementia, including restless/agitated behavior, socially inappropriate, disruptive behavior, as evidenced by frequently calling out for help and crying. Care plan interventions included: assessment for pain, developing activity plan centering around interests and history that takes lifetime values, attitudes, leisure patterns and psychosocial well-being into consideration, treating mood distress through medication therapy or individual counseling, inviting to worship services, using reassuring phrases to help minimize the feelings of fear and anxiety, offering non-pharmacologic interventions when calling out, providing consistent, trusted caregiver when possible, removing resident from environment if needed, monitoring for medication side effects, postponing activity if combative or resistive, listening and remaining calm, allowing to express feelings, and providing empathy, encouragement, and reassurance. The 4/1/23 to 4/22/23 activity participation record received from DON on 4/24/23, revealed Resident #6 participated in socializing activity (no documentation indicated whether in or out of room) 63% of days, music 36% and spiritual/religious services 0%. -There were no refusals indicated on the record. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity focus of the care plan, revised on 2/7/23, indicated that Resident #6 thought it was important to engage in daily routines that she found meaningful. The care plan noted the following preferences: Christian faith was important to her, loved to talk about past baking and cooking experiences, loved music and preferred [NAME] and Country Western music, liked keeping up on the news through use of TV (television), getting nails done, socializing with others, attending music performances, and it was important to her to vote. The social services (SS) progress note on 4/20/23 at 3:19 p.m. documented the SS was directed by staff to reach out to the family of Resident #6. The social services director (SSD) reached the grandson of Resident #6. The resident spoke with him, spoke clearly and was understood by grandson, then the resident was calm after the call with no yelling and had a better dinner experience. Nursing progress note reported that the resident screamed out when awake at the following times: 3/15/23 at 12:27 p.m., 3/25/23 at 12:36 p.m., 3/31/23 at 11:12 a.m., 4/9/23 at 11:29 a.m., 4/10/23 at 11:20 a.m., 4/12/23 at 5:48 p.m., and 4/13/23 at 3:13 p.m. Per nursing note, on 4/9/23, when asked what was wrong, the resident stated that she wanted someone to sit with her. E. Change in medication regimen Seroquel dose was increased from 112.5 milligrams per day to 150 milligrams per day on 4/19/23 with the associated diagnosis of visual hallucinations/dementia. Behavioral tracking was noted for Seroquel. There were no target behaviors associated with the Seroquel. F. Interviews An unidentified CNA was interviewed on 4/19/23 at approximately 10:00 a.m. The CNA said Resident #6 called out for help frequently during the day. Resident #53 was interviewed on 4/19/23 at 1:00 p.m. Resident #53 ' s room was directly across from Resident #6 room, said that the resident was yelling help all of the time during the day, and sometimes the resident began yelling at 4:30 a.m. Resident #53 said it had been going on for a long time. CNA #2 was interviewed on 4/23/23 at 8:40 p.m. CNA #2 said he cared for Resident #6 for several years and has found low volume Spanish music seemed to help the resident calm down. She did well when the CNA would sit and talk with her for a little while. The CNA said he had not had specific training to manage the behaviors of Resident #6. LPN #3 was interviewed on 4/23/23 at 9:00 p.m. LPN #3 said Resident #6 called out for help sometimes during the night and usually calmed with reassurance. The LPN said that she usually checked with Resident #6 to see if she had pain and there were times that she needed Ibuprofen at night. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity director (AD) was interviewed on 4/24/23 at 4:00 p.m. The AD said Resident #6 was not on a formal one-to-one program. The AD stated the CNAs got her up into her wheelchair and then assisted her to activities and Resident #6 often thought she was falling out of the chair when she was sitting up. The AD acknowledged Resident #6 did call out from her room for assistance. The AD said someone from activities department tried to see Resident #6 at least once per week, when the resident tolerated. The activities department had not had volunteers to help this resident to keep her company due to COVID, and AD stated she was working on it. The AD acknowledged the resident's socialization needs were not being met. The director of nursing (DON) was interviewed on 4/24/23 at 4:45 p.m. The DON said she was aware that Resident #6 called out for help on a daily basis. She said different things worked in the past for Resident #6 that no longer worked. There were many attempts geared at helping the resident through diversional activities. The DON said they had re-implemented things they had done before to see if they would work. The DON said when the resident was calling out, staff should not walk by her room without going in to ensure resident needs were being met. The DON stated that the social services department offered training early 2022 regarding how to deal with behavioral issues, like those of Resident #6. Dementia training was provided annually. Daily rounds occurred on residents. Resident #6 has not been addressed in the interdisciplinary meeting (IDT) team meeting. The DON was not aware that the recent Seroquel medication was increased. The social services director (SSD) was interviewed on 4/24/23 at 6:00 p.m. The SSD said she was aware that Resident #6 often yelled out for help. The SSD said she had reached out to the family of the resident, the school of blind, psychiatrist and arranged to get the resident on call with her grandson. The SSD indicated that these strategies did not resolve issues and said she did not have staff to be one-to-one with Resident #6. III. Resident #19 A. Resident status Resident #19, age 75, was admitted on [DATE]. According to the April, 2023 CPO, diagnoses included dementia with agitation, type 2 diabetes, dysphagia (swallowing difficulty)and osteoarthritis. The 2/18/23 minimum data set (MDS) assessment indicated that a brief interview for mental status could not be conducted for this resident. The staff assessment of mental status indicated memory problems with severely impaired decision making. No behavioral symptoms directed at others such as verbal/vocal screaming or disruptive sounds. No mood interview was conducted because the resident rarely/never understood. B. Observations On 4/17/23 at 12:30 p.m. Resident #19 was in a wheelchair and was being assisted with her meal by staff in the dining room. The resident yelled out five times during lunch with other residents present. Staff were present, but did not respond. Resident #19 said I want to die them once. On 4/18/23 at 2:34 p.m., the resident yelled at the CNAs in the room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/23 at 9:52 a.m., the resident was sitting in a wheelchair next to bed. The television was on and there were lack of personal items or decor in the room. On 4/19/23 at 10:05 a.m., the resident yelled out two times in fifteen minutes. On 4/20/23 at 2:24 p.m., the resident was sitting in her room. The television was on, but it was on closed caption and the volume could not be heard. C. Record review The care plan for Resident #19, last revised 4/6/23, identified socially inappropriate/maladaptive behavior related to her dementia. Interventions included assessment for pain on regular basis, developing an activity plan centering around Resident #19 interest and history, that takes lifetime interests, attitudes, leisure patterns, and psychosocial well-being into consideration. Other interventions included using frequent reassuring phrases to help minimize feelings of fear or anxiety, and non-pharmacologic interventions. Care plan identified focus of need for assistance with activities, last revised 3/13/23, which included a one-to-one program as tolerated. Interventions included introducing a calendar of events, highlighting opportunities to participate in activities of interest, participation in Catholic services weekly as tolerated, individual accommodations with decreased stimuli, and invitation to music/entertainment as tolerated. Care plan focus of verbal behaviors with staff, revised 4/6/23, included the following interventions: monitoring medications for side effects, monitor for pain, evaluate circumstances (triggers) of resident behavior, evaluate need for psychological consult, provide consistent, trusted caregivers, remove resident from environment as needed, and divert by giving alternative objects or activities. Review of the 4/1/23 to 4/22/23 activity participation record revealed that Resident #19 participated in social activity (talking on phone, social/talking, not documented whether in or out of room) 63% of the time and relaxing (looking out window, resting) 63% of the time. -No documentation was noted for refusal of any activities. D. Interviews An unidentified CNA was interviewed on 4/19/23 at approximately 10:00 a.m. The CNA said Resident #19 and another resident in the hallway yelled out frequently. LPN #3 was interviewed on 4/23/23 at 9:00 p.m. LPN #3 said that she knew he residents well, and Resident #19 was usually calm during the night and did not yell out. LPN #3 said that she only yelled out when moved. LPN #1 was interviewed on 4/24/23 at 2:00pm. LPN #1 said Resident #19 could not coordinate to hold finger foods in her hands to feed herself. Staff needed to assist Resident #19 for all of her meals. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD was interviewed on 4/24/23 at 4:05 p.m. The AD said Resident #19 had declined a lot over the past year. She used to participate in activities and often sat in the front lobby. The AD stated the resident did not know who she was talking to. The AD said she had tried to arrange activities with Resident #19 and planned to put this resident on a one-to-one schedule, but had not yet done it. The AD said Resident #19 hit and grabbed others, which made it difficult. The AD said Resident #19 had a television and radio in the room. The AD stated, I don't think that her socialization needs are being met at the moment. The DON was interviewed on 4/24/23 at 4:45 p.m. The DON stated Resident #19 recently moved to a different unit and there has been a change of staff in the unit. The DON said she would like to see what therapy services could be done for Resident #19. The DON said that dementia care had not been a topic of discussion at quality assurance meetings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47024 Based on interviews, record review and observations, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value, palatable in taste, texture, appearance and temperature. Specifically, the facility failed to ensure: -Resident food was palatable in taste, texture, appearance and temperature; -Meals were served at a palatable temperature; and, -Condiments were provided with meals. Findings include: I. Resident interviews Resident #45 was interviewed on 4/17/23 at 10:06 a.m. The resident said the food was not good. She said she had complained that when the facility did not have french fries or tater tots, they gave the residents a blob of mashed potatoes. She said she had taken pictures of the pizza that was not appetizing and showed the dietary manager (DM) so he could see what it looked like. She said she had asked for salad for lunch and dinner because the vegetables were overcooked. She said the facility did not have any dressing and they informed her that they did not have the ability to make any. She said the facility overcooked the chicken so it was too dry. Resident #67 was interviewed on 4/17/23 at 10:07 a.m. The resident said he was not a picky eater but when he took the lid off the previous day's breakfast, it smelled like burned hair. He said lunch was ham, it was brown/purple and shriveled up. Resident #31 was interviewed on 4/17/23 at 10:10 a.m. The resident said sometimes the meals were not that great. Resident #4 was interviewed on 4/17/23 at 10:18 a.m. The resident said she had soupy oatmeal and she liked it better when it was thick. Resident #20 was interviewed on 4/17/23 at 10:22 a.m. The resident said the eggs were cold and hard. Resident #81 was interviewed on 4/17/23 at 10:26 a.m. The resident said breakfast had been an egg sandwich and it was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29 was interviewed on 4/17/23 at 10:49 a.m. The resident said she did not like breakfast. She only ate the egg and the oatmeal was watery and it did not look like regular oatmeal. She said over the last several days breakfast had been no good, it was an egg between two slices of bread that had not been toasted with cheese. She said she could not believe what they served the residents to eat. Resident #8 was interviewed on 4/17/23 4:58 p.m. The resident said most of the time the food was cold, especially since she could not go to the dining room. Resident #83 was interviewed on 4/18/23 at 12:00 p.m. He said the food at the facility was not edible therefore he purchased his own food to keep in his room. He said the staff tried to convince him to eat the facility food but he would not eat it. He said the food at the facility had no flavor. Resident #53 was interviewed on 4/19/23 at 1:00 p.m. The resident said the meatloaf was terrible. II. Resident council interview Resident council was interviewed on 4/20/23 at 11:00 a.m. 12 residents attended and participated in a resident council meeting. The majority of the residents stated the food was terrible, awful and had no flavor. One resident said sometimes the hamburgers were under cooked. Another resident said the food was not prepared properly and was served cold. One resident said the fish had been served raw a few times. Residents reported the facility had run out of food and this had happened numerous times. One resident said he had voiced his concern about the food and nothing happened to resolve the problem. One resident said she made her own meals at least twice a week. One resident said he had food enhancers such as crackers, beef jerky, peanut butter, cheese wiz, salsa and chips and salami kept in his room. He said he had seasonings to give his food some flavor. III. Observation The kitchen was continuously observed on 4/19/23 at 7:30 a.m. until 8:30 a.m. for the breakfast meal. Food temperatures at the serving table were: -Pureed eggs 102.5 degrees F; and, -Pureed cinnamon rolls 95.1 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meals were not being served at 7:55 a.m. The first delivery cart went to the floor for delivery of breakfast at 8:16 a.m. and serving ended at 8:30 a.m. Only trays that had requested brown sugar had sugar, none of the trays had salt or pepper or any other kind of condiment. The room trays were served on warmed plates, with an insulated cover. However, the plates did not have a hot pellet to keep the plate warm. A test tray of pureed breakfast items was tested at 8:32 a.m. by four surveyors. There were no condiments, including sugar, salt or pepper, available. The temperatures of the meal were: -The eggs were 91 degrees F and described as bland, gritty and not flavorful; -The cinnamon rolls were 82.9 degrees F and described as gummy, gluey in texture and had small chucks of dough in it; -The oatmeal was 120 degrees F and was described as watery, bland, not sweet and was liquidy; and, -The milk was 42 degrees F. IV. Record review Dining committee meeting minutes dated 3/28/23 at 2:00 p.m. documented the residents complained about the menu and food being delivered cold. The resident council minutes from 3/28/23 read in pertinent parts (name of resident) said the kitchen has been running out of foods. Residents are complaining about having fish and chicken all the time and would like different options. V. Staff interviews The dietary manager (DM) and area dietary manager (ADM) were interviewed on 4/20/23 at 2:32 p.m. The DM said he was aware there had been food complaints. He said that the complaints that he had heard from residents included the food required more seasoning. He said the residents did receive salt with their meals, but did not want to add more salt to the food, as some residents could not have salt. He said he heard complaints on repetitive food items and requesting different types of deserts. The DM said the plate warmers were going out and needed to be replaced. The ADM said the facility has not had the heating pellets for over a year. She said that the facility was hoping to get some of the heating pellets for the room trays. The DM said he was required to complete one test tray a month. He said due to the resident complaints, he recently started a food committee. He said the menu was about to change. 42193 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48114

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, interviews, and record review the facility failed to provide snacks for residents who want to eat at non-traditional times or outside of scheduled meal times. Specifically, the facility failed to: -Provide enough snacks for residents; -Ensure residents were able to obtain snacks after the kitchen closed; and, -Ensure snacks were held at the appropriate temperatures. Finding include: I. Facility policy and procedure The Snack policy and procedure, revised September 2019, was provided by the area dietary manager (ADM) on 4/24/23 at 4:36 p.m. It read in pertinent part: snacks and beverages will be provided as identified in the individual plans of care. Bedtime snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. The Dining services department will assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime. All snacks will be properly stored for time and temperature control, as appropriate. II. Facility census At the time of the survey from 4/17/23 to 4/24/23 the facility had a census of 92 residents. III. Observations During a kitchen tour on 4/19/23 at 4:00 p.m. snacks were labeled for residents who received them; there were no other snacks available for residents. At 4:15 p.m. the nourishment room refrigerator was observed to have no snacks other than milk to be distributed and had a temperature of 50.3 degrees F. room [ROOM NUMBER] was observed on 4/20/23 at approximately 12:00 p.m. The room had a rack with multiple types of snacks the resident purchased including dried soups, crackers, nutbars, candy, and other types of snacks. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was observed 4/17/23 to 4/24/23 there were no bulk snacks available during the day, snacks were only available to residents who had an ordered snack and in the evening when the kitchen closed. IV. Resident interviews Resident #14 was interviewed on 4/18/23 at 10:20 a.m. The resident said in the past no staff member had woken him for dinner, so he was not served his dinner and went to bed hungry. Resident #43 was interviewed on 4/18/23 at 10:47 a.m. The resident said he had to get his own snacks since he was not provided snacks by the facility. On 4/20/23 at 11:00 a.m. 12 residents attended and participated in a resident council meeting. The residents said they rarely received snacks and there were usually not enough snacks for everyone. The residents said if someone was sleeping, they did not get snacks. One resident said he asked for cottage cheese for a snack and he received a little serving. Another resident said she asked for a peanut butter and jelly sandwich and it had barely any peanut butter and jelly on it. One resident stated that he had food enhancers such as crackers, beef jerky, peanut butter, cheese wiz, salsa and chips and salami kept in his room. V. Staff interviews The dietary manager (DM) was interviewed on 4/19/23 at 4:15 p.m. The DM said the snacks would be placed in the nourishment refrigerator for overnight use after the dinner meal. He said the kitchen would make sandwiches, applesauce and other items available at that time. The DM and the ADM were interviewed on 4/20/23 at 2:32 p.m. The DM said there was a list of residents who received snacks and they prepared extras for any resident that wanted something. The DM said they had decided how many to prepare and did not send out snacks for everyone to reduce waste. The supplement shakes were only available to those with a physician's order. Certified nurse aide (CNA) #2 and CNA #7 were interviewed on 4/23/23 at 8:40 p.m. The CNAs said they have limited snacks for their unit. They said snacks were not available at least four times a week. CNA #7 showed a metal container with a few yogurts with names on them and health shakes, the CNA said when she went to the kitchen at dinner, she grabbed some graham crackers. CNA #7 said there were not enough snacks for all the residents. CNA#7 said she had bought snacks for the residents. CNA#7 said the administration knew there were not enough snacks for all of the residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #4 was interviewed on 4/23/23 at 8:45 p.m. She said the staff did not have snacks quite a bit of the time. She said she had to go look at the other units to see if they have any snacks. She said the CNAs and herself had to buy snacks for the residents. She said they did not have access to the kitchen when it closed after dinner. CNA #8 was interviewed on 4/23/23. The CNA said the staff did not always have snacks. He said he looked on other units for any extra snacks. He said a snack list came out with the assigned snacks with resident names but not enough snacks for other residents not on the list. VI. Record review A list of residents with orders for snacks, delivered by the ADM on 4/24/23 at 4:36 p.m. It documented 61 residents had orders for snacks. Of the 61 residents who received snacks, 20 received a supplement shake. This list did not indicate how often residents should receive snacks. Snacks included supplements, yogurt, pudding, peanut butter and jelly sandwiches, other types of sandwiches and cookies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47024 Based on observation and interviews the facility failed to ensure the dietary department followed safe practices to prevent the potential contamination of food and spread of food-borne illness through proper kitchen sanitation procedures. Specifically, the facility failed to -Ensure meat was thawed appropriately; -Ensure food was kept at the appropriate temperature; -Ensure ready to eat food was handled appropriately; and, -Ensure health shakes were dated when thawed. Findings include: I. Ensure meat was thawed properly appropriate food temperatures 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 read in pertinent part, potentially hazardous foods (time/temperature control for safety foods) shall be thawed: A. Under refrigeration that maintain the food temperature at 41 F (5 C) or less; or B. Completely submerged and with packaging removed under running water: 1. At a water temperature of 70 F (21 C) or below, 2. With sufficient water velocity to agitate and float off loose particles in an overflow. B. Observation On 4/17/23 at 8:45 a.m., there was a box of ground beef defrosting on the sink. There was no water running on the ground beef or it was not submerged under running water. -At 9:40 a.m. The hamburger continued to sit on the sink defrosting. II. Food temperatures of cold and hot food items were not held at the proper temperature to reduce the risk of food-borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. B. Ensuring holding temperatures 1. Observation The kitchen tray line was continuously observed on 4/19/23 at 7:30 a.m. until 8:30 a.m. for the breakfast meal. Food temperatures at the tray line were as follows: -Pureed eggs 102.5 degrees F; and, -Pureed cinnamon rolls 95.1 degrees F. The food temperatures on the tray line after the last resident was served on 4/24/23 at 1:09 p.m. were as follows: -Broccoli was 127.1 degrees F; -Chicken dijon was 132.6 degrees F; -Pureed chicken was 121.5 degrees F; and -Ground chicken was 124.3 degrees F. The pudding and supplement shakes were not being stored in a cool container. The temperature of pudding to go with some meals was 49.6 degrees F and supplement shakes were 54.2 degrees F. 2. Medication carts 4/19/23 -At 2:41 p.m. during a tour with the dietary manager (DM) it was observed there was pudding on the medication carts. The temperature of the pudding on the 300/400 hall medication cart #1 was 80.7 degrees. The pudding on the medication cart #1 on the 500/600 hallway had a temperature of 54.9 degrees, mediation cart #2 pudding had a temperature of 44.3 degrees. The pudding containers had no mechanism to keep them cold. On 4/20/23 at 12:15 p.m., multiple medication carts in the facility had pudding cups in non-cooled containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Staff interviews The cook was interviewed on 4/24/23 at 1:15 p.m. The cook said the food on the steam table should be held at 150 degrees and above. Registered nurse (RN) #1 was interviewed on 4/19/23 at 3:55 p.m. The RN #1 was interviewed with the DM present. The RN said she was not sure what the temperature of the pudding should be. She said that the nurse was responsible for preparing the mechanism to keep the pudding cold. But she used a coffee cup. Licenced practical nurse (LPN) #2 was interviewed on 4/19/23 at 4:00 p.m. LPN #2 was interviewed with the DM present. The nurse said she filled the container with ice but it melted quickly. She said there was not a thermometer in the medication cart to check the temperature of the pudding. The DM and the regional area dietary manager (ADM) were interviewed on 4/24/23 at 2:32 p.m. The DM said the food tray items needed to be at 135 degrees F for hot foods and cold foods needed to be at 41 degrees F and below. He said that he was newer in his position, but that he had been providing training to the staff. The ADD said the food should be heated to 165 degrees F prior to service if it was below 135 degrees F before it was served. The DM said the kitchen made the pudding with milk, then portioned it out into individual cups. III. Ensure ready to eat food was handled appropriately A. Professional reference The FDA Food Code (2022) ch.2 pp. 5, 18-19, read in pertinent part: Employees are preventing cross-contamination of ready to eat foods with bare hand by properly using suitable utensils such as tongs or dispensing equipment; Food employees shall keep their hands and exposed portions of their arms clean, using the following cleaning procedure: rinse under clean, running water, apply cleaning compound, rub together vigorously for at least 10 to 15 seconds paying particular attention to removing soil, thoroughly rinse under clean running water and immediately drying; Food employees shall clean their hands immediately before engaging in food preparation including working with exposed food, clean equipment and utensils; after handling soiled equipment or utensils, before donning gloves to initiate a task that involves working with food. B. Observations On 4/18/23 at approximately 5:00 p.m., an unidentified certified nurse aide (CNA) was observed to touch a sandwich with bare hands and hand it to the resident. On 4/19/24 at 7:15 a.m., the cook was observed to pick up the cinnamon roll with her gloved hand. However, she had been touching other items such as the tray line tickets, a cart which was nearby. (continued on next page)

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	065232	A. Building B. Wing	04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/24/23 at approximately 11:45 a.m. during observation of lunch service the dietary assistant (DA) #1 picked up a lunch roll with her bare hands and placed it on a resident tray. DA #2 was observed picking up ready to eat hamburger buns with soiled gloves after handling utensils and other non-food items, and failing to wash hands and put on new gloves. The DM told DA #2 to go wash his hands. C. Interviews The DM and ADM were interviewed on 4/20/23 at 2:32 p,m. The DM said when handling ready to eat foods the staff were supposed to take the gloves off each time and wash their hands. He acknowledged that this did not happen with DA #2 until after he asked DA #2 to go wash his hands. He said utensils could be used also. IV. Health shakes A. Facility standards The Labeling and Dating inservice, undated, was delivered by the ADM on 4/24/23 at 4:36 p.m., it read in pertinent part Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a first in first out manner. Guidelines - items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of removal from the freezer and an appropriate 'use by' date. Leftovers must be labeled and dated with the date they were prepared and the 'use by' date. All ready to eat, time/temperature control for safety foods that are to be held for more than 24 hours at a temperature of 40 degrees F or less. B. Observation and record review The health shakes label documented to store frozen and to discard after 14 days when thawed. During the initial walk-through of the kitchen on 4/17/23 at 8:45 a.m., there were two boxes with health shakes which were defrosted. Box #1 had 13 shakes and box #2 had 12 health shakes. There were no dates on the carton to identify when they were thawed. The nourishment refrigerator was observed on 4/23/23 at 8:45 p.m. There were 12 thawed health shakes in the refrigerator, however, none of them had dates on the health shakes. The DM and ADM were interviewed on 4/20/23 at 2:32 p,m. The DM said the health shakes were to have dates on the health shakes as to when they were pulled. He acknowledged the thawed shake needed to be discarded after 14 days.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 20287 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to resident rights, quality of life, quality of care and infection control. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Plan, last revised on 8/5/22, was received from the director of nurses (DON) on 5/18/23. The plan read in pertinent parts, All staff and stake holders are involved in QAPI to improve the quality of life and quality of care that our patients and residents experience. The Center's approach to QAPI culture and processes is standardized by implementing the following key elements: data driven and comprehensive, addressing all aspects of care, quality of life and resident centered rights and choice. Review, analyze trends and identify potential improvement opportunities for performance data where trends are worsening or levels have exceeded targets are completed prior to the quality assurance performance improvement committee. II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct F584 During the abbreviated survey on 2/9/22 F584 (home like environment) was cited at a E scope and severity. During the recertification survey on 4/24/23, the facility was cited at a E scope and severity. F676 During the abbreviated survey on 2/9/22 F676 (activities of daily living) was cited at a D scope and severity. During the recertification survey on 4/24/23, the facility was cited at a G scope and severity. F677 During the abbreviated survey on 6/1/22 F677 (activities of daily living for dependent residents) was cited at a E scope and severity. During the recertification survey on 4/24/23, the facility was cited at a E scope and severity. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F744 During the recertification survey on 7/8/21 F744 (dementia care) was cited at a D scope and severity. During the recertification survey on 4/24/23, the facility was cited at a D scope and severity. F804 During the abbreviated survey on 6/1/22 F804 (nutritive value, palatability) was cited at a E scope and severity. During the recertification survey on 4/24/23, the facility was cited at a E scope and severity. F812 During the abbreviated survey on 2/9/22 F812 (kitchen sanitation) was cited at a F scope and severity. During the recertification survey on 4/24/23, the facility was cited at a F scope and severity. F867 During the recertification survey on 7/8/21 F867 (quality assurance) was cited at a F scope and severity. During the recertification survey on 4/24/23, the facility was cited at a F scope and severity. F 880 During the recertification survey on 7/8/21 F880 (infection control) was cited at a L scope and severity. During the abbreviated survey on 2/9/22 F 880 (infection control) was cited at a E scope and severity. During the recertification survey on 4/24/23, the facility was cited at a F scope and severity. III. Cross-reference citations F550 Cross-reference F550 Dignity: The facility failed to ensure residents were treated with respect and dignity. F565 Cross-reference F565 Resident group response: The facility failed to hold resident council meetings consistently in a private area and respond to their grievances and concerns. F574 Cross-reference F574 Required notices and contact information: The facility failed to ensure the facility posted notices were readable and in a prominent area. F576 (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F576 Right to forms of communication: The facility failed to ensure residents received privacy with mail. F577 Cross-reference F577 Right to survey results: The facility failed to ensure the previous Federal andState survey results were available. F809 Cross-reference F809 Snacks: The facility failed to ensure residents were offered evening snacks. IV. Interviews The DON was interviewed on 4/24/23 at 7:32 p.m. The interim nursing home administrator (INHA) was not available to attend the interview. The DON said the INHA had been at the facility for a few months. She said the QAPI committee met monthly with all department heads, the medical director, the pharmacist and when available a floor staff. The DON said the meeting had an agenda. She said the agenda changed monthly. She said areas were identified from grievances, audits and concerns from residents and family. The QAPI committee looked for trends and then root causes and then put a performance improvement plan in place. The DON said snacks were not provided to residents had been brought to the QAPI meeting in January 2023. She said the kitchen was going to order snack carts, so the snacks would be passed out on the cart, however, the carts were too small so they needed to reorder. The DON said infection control was discussed every meeting and they reviewed the antibiotics and tracking and trending. She said the committee had not identified the lack of cleaning high touch areas, offering hand washing to residents or cleaning durable medical equipment. The DON said resident rights issues and dignity had not been identified in the QAPI program. The DON said the privacy of communication (mail) had been discussed a little while back with the previous NHA and activity director. The decision was to have packages opened in front of an activity associate to ensure medications were not in the packages. The DON said overall she believed the facility had a good QAPI program, however, the participants for the QAPI needed to have a better understanding of the process and how to identify items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection for two out of three units at the facility. Specifically, the facility failed to: -Ensure high touch areas were cleaned; -Ensure nursing staff disinfected shared equipment (vitals machines and lifts) between residents; -Ensure residents were provided with an opportunity to participate in hand hygiene prior to meals; and, -Ensure residents' personal property were labeled and stored appropriately. Findings include: I. Ensure housekeeping staff were following the proper cleaning techniques for cleaning resident rooms and disinfecting high frequency touched areas A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical recommendations for routine cleaning and disinfection procedures in healthcare institutions: a narrative review. The Journal of Hospital Infection. 2021 Jul;113:104-114 was retrieved on 4/26/23 revealed, in pertinent part: High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. The Centers for Disease Control (CDC) Environment Cleaning Procedures https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html# retrieved on 4/26/23 read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-bedrails -IV (intravenous) poles -sink handles -bedside tables -counters -edges of privacy curtains -patient monitoring equipment (keyboards, control panels) -call bells -door knobs Proceed From Cleaner To Dirtier Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: -During terminal cleaning, clean low-touch surfaces before high-touch surfaces. -Clean patient areas (patient zones) before patient toilets. -Within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone. -Clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Facility policy and procedure The Infection Control policy and procedure, dated 10/17/22, was received on 4/19/23 from the director of nurses (DON)read in pertinent part, Clean and disinfect the environment, especially high touch surfaces, using an EPA (Environmental Protection Agency) approved, hospital grade disinfectant. C. Observations The front entry had a computer which must be signed into by any visitors and all staff. The computer needed to be touched to enter a name and phone number. Throughout the survey from 4/17/23 through 4/24/23, the computer had not been disinfected. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/24/23 at 12:02 p.m., housekeeper (HSK) #2 was observed to clean room #x. The HSK cleaned the door handle to the bathroom, however, she did not clean the pull cord, the light switch, the handles of the sink, the door knob to the entry of the room. D. Interviews HSK #2 was interviewed on 4/24/23 at 12:15 p.m. The HSK said she was newly hired. She said high touch areas got cleaned once a day. She said she did not have any training on how frequently the high touch areas needed to be cleaned. The DON and the infection control preventionist (IP) were interviewed on 4/24/23 at 6:00 p.m. The DON said the resident rooms were cleaned daily. She said the room cleaning should include the light switches, pull cords and door knobs. She said other high touch areas needed to be cleaned frequently. The IP said the entrance computer needed to be cleaned in between each usage. He said the receptionist was responsible to ensure it was cleaned in between uses. The HSK supervisor was interviewed on 4/24/23 at 6:30 p.m. The HSK supervisor said HSK #2 had received training for three days prior to working alone. She said she would provide more education on ensuring the high touch areas were cleaned in the resident rooms. II. Failed to ensure residents were provided with an opportunity to participate in hand hygiene prior to meals A. Professional reference The Centers for Disease Control (CDC) Hand Hygiene updated 2/7/23, retrieved on 4/27/23 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html revealed in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. Practicing hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate SARS-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The CDC recommends using ABHR with greater than 60% ethanol or 70% isopropanol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Infection Control policy and procedure, dated 10/17/22, was received on 4/19/23 from the DON, read in pertinent part, HCP (healthcare personal) will assist/remind patients to complete hand hygiene as needed per policy. C. Observations On 4/17/23 at approximately 12:00 p.m., the residents in the assisted dining room were not provided the opportunity to perform hand hygiene. The meal trays were passed out, without staff offering hand hygiene. On 4/18/23 at 5:18 p.m., an unidentified CNA served the dinner meal to Resident #42. The CNA put a sanitizing wipe on his lap. However, the resident did not use it, and no staff helped him. He then began to eat his meal. The resident nails were visibly soiled. At 5:20 p.m. an unidentified CNA asked the other unidentified CNA if hand hand hygiene was offered to residents down the 600 wing before dinner trays were passed out; he said yes they were all provided with hand hygiene care. However, continuous observations between 2:00 p.m. and 5:30 p.m., hand hygiene was not observed to be offered or provided.The CNA did not have the hand wipes on him when trays were passed out. On 4/19/23 at 4:56 p.m., the room tray cart arrived on Rock Canyon station. The trays were passed to rooms by CNAs and the health information manager (HIM). The HIM walked into room [ROOM NUMBER] and served a room tray to the resident. No offering of hand hygiene was provided. CNA #11 was observed to pass several trays without offering hand hygiene to the residents. D. Interview The DON was interviewed on 4/20/23 at approximately 3:00 p.m. The DON was informed that hand hygiene prior to meals being served were not offered. The DON said all staff were aware that residents' hands needed to be washed prior to the meal being served. She said the facility had completed training on the importance of offering hand hygiene. III. Failure to clean medical equipment A. Facility policy and procedure The Infection Control policy and procedure, dated 10/17/22, was received on 4/19/23 from the DON, read in pertinent part, Clean and disinfect patient care items using appropriate EPA approved, hospital grade disinfectant and following manufacturer's instructions. B. Observations On 4/18/23 at approximately 1:00 p.m., an unidentified CNA was observed to take the vitals of a resident. She then wiped the vital sign machine with a sanitation wipe which was designated to be used for hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/18/23 at 4:24 p.m., CNA #10 was observed to use the hoyer (mechanical) lift on a resident. The CNA then immediately put the hoyer lift at the end of the hall for storage. She failed to clean the lift. C. Interview The DON and the IP were interviewed on 4/24/23 at 6:00 p.m. The IP said the wipes which were to be used on the durable medical equipment was the Micro kill, or a bleach wipe. The sanitation wipes which were used for hands were not be used. IV. Resident personal items A. Observations On 4/18/23 at 10:45 a.m., room [ROOM NUMBER] had an unmarked hair brush laying on the sink in a shared room. 4/24/23 -At 10:39 a.m., the shower room on the 600 hall had an unmarked hair brush with hair in it stored on the shelf. -At 10:45 a.m., room [ROOM NUMBER] a shared room, had no markings on the towel bar to distinguish which towel belonged to which resident. -At 10:46 a.m., room [ROOM NUMBER] had an unmarked hair brush and unmarked urinal not bagged in the bathroom. The towels had no markings on the towel bar to distinguish which towel belonged to which resident. One of the residents was asked which towel was his, and he said he had no idea, he used either of them. -At 11:00 a.m. room [ROOM NUMBER] had an unmarked toothbrush on the sink; no towels were marked in a shared room. -At approximately 11:00 a.m., room [ROOM NUMBER] had two bars of soap at the sink, an unmarked towel bar in a shared room. -At approximately 11:10 a.m., room [ROOM NUMBER] had no marking on the towel rack, in a shared room. The resident did not know which towel was hers versus her roommate. B. Interview The DON and the IP were interviewed on 4/24/23 at 6:00 p.m. The DON said unmarked items were the responsibility of the CNAs. The urinals needed to have a name or room number. She said the CNAs should mark all personal items, such as toothbrushes, and hair brushes or put it into a basin with a name. She said on the towel bar the towel closest to the door was bed A and the furthest was bed B. She acknowledged the residents did not know the location of their towel in a shared room. 48458