STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065355	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharmar Village Senior Care Community	1209 W Abriendo 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to address and/or act promptly upon the grievances and recommendations during resident council on issues of resident care and quality of life in the facility that were important to the residents.Specifically, the facility failed to ensure resident council grievances were addressed to resolve resident concerns related to call light response times.Findings include:I. Facility policyThe Grievance policy, dated September 2016, was received from the nursing home administrator (NHA) on 8/11/25 at 4:14 p.m. The policy documented in pertinent part, Residents must be able to file complaints and [NAME] also be assisted to file complaints, if necessary. Confidentiality of the aggravated party will be maintained as much as possible and grievances may also be submitted anonymously. The social services director (SSD) is the staff designee and Grievance Official responsible for overseeing the grievance process. The process must include an investigation, action taken to resolve the complaint and information about the resolution shared with the resident. The facility must address grievances promptly, preventing further violations while investigations are taking place. A grievance decision will be issued in writing and where appropriate, an oral explanation shall accompany the written one.II. Resident group interview Residents #18, #19, #20, #21 and #22, who were identified by the facility and assessment as interviewable, were interviewed together as a group on 8/7/25 at 2:00 p.m. The residents said call lights were not being answered timely and sometimes they had to wait in excess of 30 minutes for the call light to be answered.The residents said certified nurse aides (CNA) and other staff members answered their call lights, would say they had to come back and then they would not come back to answer the call light.The residents said they had reported their call light concerns to the resident council, however, they had not heard of any resolutions and continued to have concerns with long call light times.III. Resident council meeting minutesOn 8/6/25 at 8:35 a.m. the NHA provided the resident council minutes for April 2025, May 2025, June 2025 and July 2025. The 4/10/25 resident council meeting minutes documented residents had said call lights were not answered timely.-However, there was no documentation to indicate how the facility planned to address the residents' concern. The 5/8/25 resident council meeting minutes documented residents had said call lights were not answered timely. -However, there was no documentation to indicate how the facility planned to address the residents' concern.The 7/10/25 resident council meeting minutes documented residents had said call lights were not answered timely. The minutes documented the director of nursing (DON) would pull the call light audit reports for the three residents who had voiced concerns and review the logs with the residents. -However, the resident group interview conducted during the survey revealed residents' continued to have call light concerns (see interview above). IV. Grievances The grievance forms generated from the resident council meetings were provided by the social service director (SSD) on 8/11/25 at approximately 4:00 p.m.The 4/10/25 grievance form documented Resident #9 expressed concern that call lights were not answered timely. The (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resolution result documented by the facility revealed the facility spoke with the resident and attempted to show the resident the call light log to go over the durations of wait times with an average of seven minutes. The form documented Resident #9 refused to talk or sign the grievance. The 7/10/25 grievance form documented Resident #9 expressed concern that the call lights were too long. The resolution result documented the facility reviewed the resident's call light times. The form further documented that the facility reviewed that a pager system was being implemented no later 8/1/25. The form documented the facility acknowledged there were some longer call light times.-However, the grievance form failed to indicate how the facility planned to address the long call lights until the new pager system was in place or if the resident was satisfied with the resolution. The 7/10/25 grievance form documented Resident #12 expressed concern that the call light times were too long. The resolution result documented the facility would have a new pager system implemented by 8/1/25.-However, the grievance form failed to indicate how the facility planned to address the long call lights until the new pager system was in place or if the resident was satisfied with the resolution.V. Staff interviewsThe DON was interviewed on 8/6/25 at 1:00 p.m. The DON said the call light system was hooked to a computer. She said the call lights would ring to pagers which the CNAs carried. She said the new system had been in place for a few weeks. The SSD, the activities director (AD) and the NHA were interviewed together on 8/11/25 at approximately 4:00 p.m. The AD said the resident council meeting was held once a month. The SSD said as the residents had concerns, the grievance forms were filled out and provided to the department responsible for addressing the concern. The NHA said the grievance forms needed to have a resolution within 72 hours. She said she wanted them to be as timely as possible. She said the grievance forms demonstrated that the facility was paying attention to the call lights. She said the interdisciplinary team talked about call lights everyday. She said she wanted to make sure call lights were within reach. She said the facility implemented walkie talkies and the pager system in August 2025 to address call lights. She said the facility additionally had each resident assigned to a staff member for weekly rounds.-However, residents continued to voice concerns regarding long call wait times (see interview above). The NHA said that the call light audits had shown call lights had been answered timely. She said she had not performed audits to watch call lights and to observe to see if the lights were answered and turned off without performing the task. The DON was interviewed again on 8/11/25 at 5:38 p.m. The DON said the staff had been instructed to not turn off the call lights until the task was completed (during the survey).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that four (#1, #14, #7 and #2 of seven residents reviewed for activities received an ongoing program of activities designed to meet needs and interests, and promote physical, medical, and psychosocial well-being out of 21 sample residents. Specifically, the facility failed to offer and provide a personalized activity program for four Residents (#1, #14, #7 and #2). Findings include: I. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the August 2025, diagnoses included neurogenetic disorder with Lewy bodies (type of dementia), chronic obstructive pulmonary disease (COPD) and dementia (gradual decline in mental abilities). The 6/12/25 minimum data set (MDS) assessment revealed the resident was rarely understood, had severe decision-making impairments and had both short-term and long-term memory impairments per staff assessment. She was dependent on staff for activities of daily living (ADLs). The 4/3/24 MDS revealed it was very important to the resident to listen to music she liked, to be around animals such as pets, t to do things with groups of people and to do her favorite activities, to go outside and get fresh air when the weather was good and to participate in religious spiritual practices. B. Observations On 8/6/25 at 9:45 a.m. Resident #1 was sitting in a wheelchair in the main television room. She was resting with her eyes closed. On 8/6/25 at 9:15 p.m. Resident #1 was sitting in her wheelchair in front of the television in the common area. On 8/7/25 at 9:40 a.m. Resident #1, at activities, was sleeping in a wheelchair, for coffee and conversation. On 8/7/25 at 10:00 a.m. Resident #1 was sitting in a wheelchair in the main television room and was asleep. On 8/11/25 at 9:41 a.m. Resident#1 was asleep in her wheelchair in the main television room. D. Record review The activities care plan, revised 3/19/25, revealed the resident enjoyed both independent and group activities. The care plan documented the resident enjoyed spiritual services, being in social areas, going outside (when weather permits), music, pets/animals, dancing in her wheelchair, visiting with family/friends, watching/listening to television and outings/van rides. The care plan documented the resident liked to be around people and enjoyed listening to music. Pertinent interventions (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included encouraging and assisting group activities and encouraging participation in the activities. The July 2025 and August 2025 (8/1/25 to 8/11/25) participation logs documented that the resident attended a variety of activities. -However, review of the participation logs did not reveal pet visits were provided per the residents preference. C. Resident #1’s representatives interview The resident’s representative was interviewed on 8/7/25 at 12:07 p.m. The resident’s representative said Resident #1 enjoyed being around people and listening to music. D. Staff interviews The activity director (AD) was interviewed on 8/11/25 at 4:00 p.m. The AD said Resident #1 enjoyed being involved in group activities. She said Resident #1’s interests included spiritual services, being in social areas, going outside, music, pet visits, dancing in her wheelchair, visiting with family,watching and listening to television and outings/van rides. The AD said she did not have any documentation that the resident was offered pet visits per her preference. II. Resident #14 A. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO diagnoses included polyneuropathy (nerve function causes numbness, burning pain, and muscle weakness in arms and legs), and stroke. According to the 4/25/25 MDS the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. She was dependent on staff for ADLs. The 10/23/24 MDS revealed it was very important to listen to music she liked, it was very important to be around animals such as pets, it was very important to do things with groups of people and to do her favorite activities. It was very important to go outside and get fresh air when the weather was good and to participate in religious spiritual practices. B. Observations On 8/6/25 at 2:26 p.m. the resident was sitting in the hallway with nothing to do. She was eating popcorn. On 8/6/25 at 3:06 p.m. the resident continued to sit in the hallway with no meaningful activities. The staff were passing her in the hallway but did not say anything to her as they passed her On 8/6/25 at 3:15 p.m. Resident #14 was in her wheelchair in the common area. The television was (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on, but the resident was not watching. On 8/6/25 at 3:24 p.m., the resin continued to sit in the common area. She was observed to use her feet to self propel herself slightly down the hallway. On 8/6/25 at 4:00 p.m. Resident #14 continued to sit in the hallway with no meaningful activities. The staff passed her, but did not acknowledge her as they passed her in the hallway. C. Record review The activity care plan, revised on 11/4/24, revealed the resident preferred to be involved in group and individual activities. Interests included activity cart, arts and crafts, being social areas, card and board games, going outside, self propelling around the facility and pets/animals. Pertinent interventions included providing supplies such as books, craft supplies and games, reminding and encouraging to assist and transport to activities as needed and encouraging participation in expressed individual group activities of interest. D. Staff interviews The AD was interviewed on 8/11/25 at 4:00 p.m. The AD said Resident #14 preferred to be involved in group and individual activities. The AD said the resident enjoyed the activity cart, arts/crafts, being in social areas, going outside, Bingo, self-propelling around the facility, word puzzles, music, physical activity, outings/trips, reading material, parties/socials, pets/animals, visiting with family and watching television. III. Resident #7 A. Resident status Resident #7, age greater than 65, admitted on [DATE]. According to the August 2025 CPO, diagnoses included chronic embolism and thrombosis of inferior vena cava (blood clot), dementia, glaucoma (disease that causes decreased vision) and hypertension (high blood pressure). The 7/25/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of four out of 10. The resident was dependent on staff for activities of daily living (ADL). The MDS assessment revealed it was very important for the resident to participate with groups of people, to listen to music, to go outside to get fresh air and participate in their favorite activities. B. Observations During a continuous observation on 8/6/25 beginning at approximately 10:07 a.m. and ending at 10:45 a.m. Resident #7 was sitting in her recliner in her room. She had nothing to do. There was no music was playing. The activities calendar posted in the hallway revealed there was coffee and chat at 10:30 a.m. The staff did not ask Resident #7 if she would like to participate in coffee and chat. On 8/6/25 at 2:45 p.m. Resident #7 was sitting in her wheelchair in her room. There was no music playing in her room and her television was off. The resident did not have any engaging activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 8/6/25, beginning at 2:45 p.m. and ending at 3:24 p.m. the following was observed: At 3:05 p.m. Resident #7 yelled out, “Hey” at visitors walking past the room. No staff responded to Resident #7. At 3:08 p.m. Resident #7 yelled out, “Hey” at visitors walking past the room. No staff responded to Resident #7. At 3:10 p.m. Resident #7 yelled out, “Hey” at visitors walking past the room. No staff responded to Resident #7. At 3:13 p.m. the nurse consultant passed by the room of Resident #7 and the Resident yelled out, “hey.” The nurse consultant replied back with, “ hey” and never stopped to ask Resident #7 if she needed assistance. At 3:24 p.m. an unidentified CNA assisted Resident #7 from the bathroom placing her back in her wheelchair and leaving Resident #7 sitting alone in the middle of her room with nothing engaging in front of her. Staff did not offer an activity. On 8/6/25 at 3:50 p.m. Resident #7 was sitting in her wheelchair in the room alone with no activity, and no staff interacting with her. On 8/6/25 at 4:45 p.m. Resident #7 sitting in her wheelchair alone, still no meaningful activity or engagement. On 8/6/25 at 6:00 p.m. an unidentified staff member assisted Resident #7 back to her room leaving her alone in her wheelchair with no activity. On 8/7/25 at 11:37 a.m. Resident #7 was sitting in her wheelchair, with no meaningful activity in front of her. On 8/11/25 at 6:38 p.m. the courtesy activity cart was observed with coloring books, markers, outdated magazines, old books, and a container with random craft pieces. -The courtesy cart did not contain any materials for music, sensory or aromatherapy (see interview below). C. Resident #7’s representative interview The resident’s representative was interviewed on 8/7/25 at 12:04 p.m. The representative said activities were very important to Resident #7. The representative said the resident enjoyed being in a group activity or with other people. The representative said Resident #7 had told her that staff just wheeled her to her room and left her there. The representative said the resident had vision impairments, so she did not enjoy watching television. D. Record review The care plan, revised on 2/25/25, revealed the resident enjoyed many different activities. She (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferred group activities and liked going outside, music, physical activities and visiting with family/friends. Pertinent interventions included encouraging the resident to participate and providing the resident supplies as needed. Review of the activity participation records from 7/1/25 to 8/11/25 did not reveal the resident was offered musical activities per her preference and showed no musical activity listed/offered. E. Staff interviews The AD was interviewed on 8/11/25 at 6:00 p.m. The AD said there were five activity staff available seven days a week. The AD said Resident #7’s participation was dependent on her roommate. The AD said if her roommate refused to participate in activities then Resident #7 would refuse. The AD said Resident #7 had vision impairments and was placed near the staff for assistance when she participated in the activities. The AD said Resident #7 was not currently on a one-to-one program but said that the resident would benefit from a one-to-one program three days a week The AD said the residents were offered a courtesy cart at all hours of the day. She said the cart included items like books, crafts, fidget toys, coloring supplies, radios for music and oils for aromatherapy. CNA #4 interviewed on 8/7/25 at 2:53 p.m. CNA #4 said Resident #7 enjoyed sitting in her recliner in the afternoons and people watching in the hallway. She also enjoyed going to meals early and would verbalize when she was done. IV. Resident #2 1.Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included Alzheimer’s disease, dementia and anxiety disorder. The 6/26/25 MDS assessment revealed the resident had both short term and long term memory impairments. The resident was severely cognitively impaired with a BIMS score of four out of 15. The resident was dependent on staff for ADLs. Resident #2 was unable to verbally communicate her needs. The 12/13/24 MDS assessment revealed it was somewhat important to be around animals and it was very important to go outside to get fresh air when the weather was good to listen to music she likes. B. Observations On 8/7/25 at 3:30 p.m. Resident #2 was in the restorative dining room for a manicure activity. She was in her wheelchair facing a wall, away from the other residents at the table. The staff did not interact with the resident or adjust the direction her wheelchair was facing. On 8/7/25 at 4:15 p.m. Resident #2 was in her wheelchair in front of the television in the common area. The resident was not engaged with the television. On 8/11/25 at 2:07 p.m. Resident #2 was in her wheelchair in the common area. Resident #2 was not engaged with the television. She appeared restless and fidgeting, folding herself in half at the waist while sitting in her wheelchair. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #2’s representatives interview Resident #2’s representative was interviewed on 8/11/25 at 2:25 p.m. She said she was under the impression that her mother spent most of her time in bed, unless it was time for lunch or dinner. She said her mother loves animals, but animals did not come to the facility. C. Record review Resident #2’s activity care plan, revised on 2/24/25, revealed Resident #2’s interests included arts/crafts, parties/socials, card/board games, going outside and pets/animals. Pertinent interventions included encouraging the resident to participate in expressed individual and/or group activities of interest. Review of Resident #2’s July 2025 and August 2025 (8/1/25 to 8/7/25) activity participation logs revealed activities including card/board games, pet visits and outdoor activities were not offered to the resident. Resident #2’s July 2025 and August 2025 (8/1/25 to 8/7/25) activity participation log revealed daily participation in independent TV time. D. Staff interview The AD was interviewed on 8/11 at 6:00 p.m. She said if a resident was non-interviewable, she would interview a family member to assess family structure, religion and preferred activities. The AD said Resident #2 had a sensory mat that should have been utilized when the resident appeared restless.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#8) of two residents out of 21 sample residents. Specifically, the facility failed to ensure nursing staff followed the physician ordered pain parameters when administering as needed (PRN) pain medication to Resident #8.Findings include:I. Facility policy and procedureThe Pain Management policy, dated 2025, was provided by the nursing home administrator (NHA) on 8/11/25 at 4:14 p.m. It read in pertinent part, The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The facility, in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. The interdisciplinary team and the resident and/or the resident's representative will collaborate to arrive at pertinent, realistic and measurable goals for treatment.II. Resident #8A. Resident statusResident #8, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, anxiety, subsequent encounter for fracture with routine healing, abnormalities of gait and mobility, generalized muscle weakness and a history of falls.The 8/6/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She was dependent on staff for partial to moderate assistance for activities of daily living (ADL). B. Record reviewReview of Resident #8's August 2025 CPO revealed the following physician's orders:Pain Scale 1-10 or [NAME] pain scale, 1-3 mild pain, 4-6 moderate, and 7-10 severe. Tolerable pain level is 3 out of 10, ordered 10/1/24.Acetaminophen oral tablet, give 650 mg by mouth every eight hours as needed for mild and moderate pain, ordered 7/1/25;Tramadol HCl oral tablet 50 mg, give one tablet by mouth every eight hours as needed for severe pain, ordered 7/1/25. Review of Resident #8's August 2025 medication administration records (MAR) revealed the resident received Tramadol PRN on the following dates:-On 8/1/25 for a pain level of 5;-On 8/2/25 for a pain level of 5;-On 8/3/25 for a pain level of 5;-On 8/8/25 for a pain level of 5;-On 8/9/25 for a pain level of 5; and,-On 8/10/25 for a pain level of 6.-However, per the physician's orders for pain medication parameters, Resident #8 should have been administered acetaminophen, not tramadol, for a pain level of 5 or 6. III. Staff interviewsRegistered nurse (RN) #3 was interviewed on 8/11/25 at 10:45 a.m. RN #3 said Resident #8 had generalized pain from arthritis. She said after a PRN pain medication was administered she would return in an hour to check on the effectiveness. The director of nursing (DON) and the corporate nurse consultant were interviewed together on 8/11/25 at 2:40 p.m. The DON said the facility used the [NAME] pain scale and the faces pain scale for nonverbal residents. The DON reviewed Resident #8's electronic medical record (EMR) and confirmed the tramadol was not administered according to the physician's orders and parameters.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#3, #8 and #11) of six residents reviewed for accidents out of 21 sample residents received adequate supervision to prevent accidents. Resident #3 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric (upper thigh bone - hip fracture) fracture, acute pain due to trauma and orthostatic hypotension. The resident was known to be a fall risk upon admission due to her fall at home which resulted in the resident's left hip fracture. However, the fall assessment completed on 3/12/25 documented the resident had not fallen and was a low risk for falls. The facility implemented a fall care plan upon admission which included ensuring items were within the resident's reach.On 4/18/25 Resident #3 turned her call light on after using the bedside commode in her room. When staff had not responded to the call light after 15 minutes, the resident stood up from the commode and attempted to reach the toilet wipes, which were not within easy reach. The resident sustained a fall which resulted in her transfer to the hospital where she was discovered to have a right wrist fracture and right hip fracture which required surgical repair. Specifically, the facility failed to:-Implement effective fall interventions in order to prevent a fall with major injury to Resident #3;-Ensure fall interventions were consistently implemented for Resident #8; and,-Ensure Resident #11's foot pedals were in place on her wheelchair when staff were transporting the resident.Findings include: I. Facility policy and procedure The Accidents and Supervision policy, dated 3/1/25, was provided by the nursing home administrator (NHA) on 8/7/25 at 2:41 p.m. It revealed in pertinent part, “The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. “Identification of hazards and risks: The process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. “Evaluation and Analysis: The process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Both the facility-centered and the resident-centered direct approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk and identifying or developing interventions based on the severity of the hazards and immediacy of risk. “Implementation of interventions: Using specific interventions to try to reduce a resident’s risks from hazards in the environment. The process includes communicating the interventions to all staff, providing training as needed and ensuring that the interventions are put into action. “Monitoring and modification: Monitoring is the process of evaluating the effectiveness of care plan interventions. Modifications is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. The monitoring and modification process includes ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of new interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency and based on the individual resident’s assessed needs and identified hazards in the resident environment.” II. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture, acute pain due to trauma and orthostatic hypotension. The 3/18/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. She required full assistance of one person for bed mobility, transfers, locomotion, dressing, and toileting. The resident was incontinent of bladder and bowel. The assessment indicated the resident had a prior fall within the last month while at home, resulting in a fracture to her left hip. B. Resident and resident representative and resident representative interview Resident #3 and her representative were interviewed together via phone on 8/11/25 at 10:19 a.m. Resident #3 said she was on the commode in her room (on 4/18/25) when she pushed her call light for assistance off the toilet. She said she waited 15 minutes for staff to come and assist her but to come and assist her but no one answered her call light. She said the toilet wipes were not within reach and so she stood up from the commode to reach back behind her for the wipes and fell to the floor. Resident #3 said she laid on the floor Resident #3 said she laid on the floor until staff arrived to answer her call light. Cross reference F565 for grievances of a group related to call lights. Resident #3’s representative said the resident sustained a right wrist fracture and a right hip fracture as a result of her fall. She said the resident did not return to the facility and was discharged to another facility after her hospital stay. C. Record review The fall care plan, initiated 3/13/25, identified that Resident #3 had a potential for fall/injury related to decreased range of motion and a fall with fracture. Interventions included keeping frequently used items within reach (initiated 3/13/25), keeping the call light within reach (initiated 3/13/25), assisting with transfers as needed (initiated 3/13/25), the resident was to be supervised during toileting activities (initiated 4/18/25) and encouraging the resident to use a reacher device (initiated 4/21/25). -However, the interventions for supervision during toileting and encouraging the resident to use a reacher device were not implemented until after the resident’s fall and transfer to the hospital on 4/18/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Additionally, the toilet wipes were not within easy reach of the resident, which caused her to have to stand up and reach behind her to reach them (see resident interview above). The admission fall risk assessment, dated 3/12/25, revealed Resident #3 was a low risk for falls. -The fall risk assessment documented the resident had not fallen, however, the resident was admitted with a fractured hip related to a fall at home. The 4/17/25 physician’s follow-up progress note documented Resident #3 was still non weight bearing on her leg, still needed help with transfers and remained a fall risk. The 4/18/25 nurse progress note, documented at 9:35 p.m., revealed Resident #3 was sent to the hospital for Xrays. -The progress note did not document the reason the resident was sent to the hospital for Xrays or what time she was transported from the facility. The 4/18/25 nurse progress note, documented at 5:49 a.m., revealed the nurse called the hospital and was informed that Resident #3 had been admitted to the hospital. -The progress note did not indicate the reason the resident had been admitted to the hospital. The 4/19/25 nurse progress note, documented at 7:19 a.m., was documented as a late entry progress note (for the 4/18/25 fall). The progress note documented Resident #3 was assessed by the registered nurse (RN) for immediate trauma/injury. Resident #3 reported pain at her right hip with guarding (physical response to attempt to protect an injury) while being assessed. The resident was transferred to her bed with staff assistance. Once in bed, Resident #3 complained of right wrist pain with some deformity noted at the ulnar bone (long bone of the arm, on the outside of the wrist). A small amount of blood was noted from a skin tear at the ulnar side of her wrist. The physician and the resident’s representative were notified and the physician gave orders to send the resident to the hospital for evaluation and treatment. The resident was transported to the hospital via ambulance at approximately 7:30 p.m. The 4/21/25 fall/post fall progress note documented that Resident #3 stated she was reaching for the wipes and fell to the floor, extending her right hand as she was falling. The resident had turned her call light on and then reached for the wipes. The resident overreached and fell off the bedside commode. The note documented the certified nurse aide (CNA) who placed Resident #3 on the bedside commode placed items where the resident directed them to be placed. Review of Resident #3’s call light records for 4/18/25 revealed Resident #3 pushed her call light at 6:18 p.m. The duration for the 6:18 p.m. call light was 25 minutes and 19 seconds. D. Staff interview The director of nursing (DON) was interviewed on 8/11/25 at 2:40 p.m. The DON said Resident #3 initially admitted to the facility for a left hip fracture that occurred at home. The DON said Resident #3 was very careful about using the call light and waiting for staff. She said not waiting for staff to answer her call light to assist her before reaching for the wipes (on 4/18/25) was out of character for the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However, Resident #3 said she turned her call light on and waited for 15 minutes for staff to come and assist her before attempting to get the wipes herself (see resident interview above). -Additionally, per Resident #3’s 4/18/25 call light log, the resident turned her call light on at 6:18 p.m. and the call light was not answered for over 25 minutes (see record review above). The DON said the facility changed nursing shifts at 6:00 p.m. and staff performed walking rounds at that time. She said the general goal for answering call lights was six minutes. She said Resident #3’s fall occurred during shift change, which was not an excuse, but justified the long wait time for the resident’s call light. The DON said staff found Resident #3 on the floor when they went in to answer her call light. She said Resident #3 did not vocalize her need for assistance. -However, Resident #3 requested assistance from staff by pushing her call light over 25 minutes before she was found on the floor when a staff member answered her call light. The DON said Resident #3 was sent out to the emergency room after the fall and was found to have a fracture to her right wrist and right hip. She said the resident did not return to the facility. The DON said a fall assessment was completed for residents at the time of admission. She said the assessment gathered information from the family in an attempt to mitigate potential issues at the time of admission. She said Resident #3 should have been documented as a high risk for falls due to her fall history at home. The DON said the facility implemented standard fall interventions for residents at admission. She said some interventions implemented were non-skid socks, fall mats, low bed position and a “call don’t fall” sign. III. Resident #8 A. Resident status Resident #8, age greater than 65 years, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, anxiety, subsequent encounter for fracture with routine healing, abnormalities of gait and mobility, generalized muscle weakness, and a history of falls. The 8/6/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. She was dependent on staff for partial to moderate assistance with most ADLs. Resident #8 has abnormalities of gait and mobility, is unsteady on her feet, and had a history of falls. The MDS assessment indicated the resident had a history of falls. B. Observations and staff interview On 8/6/25 at 9:10 p.m., Resident #8 was in her room, lying in bed. -The resident did not have the tactile wedge pillow (triangle-shaped pillow) in use. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/7/25 at 4:20 p.m. Resident #8 was in her bed in her room, without a tactile pillow in place. CNA #1 confirmed the tactile pillow was not in use. She said the pillow was put next to the wall, because she liked to roll on her right side. CNA #1 said the pillow was used to keep her arm on the bed, preventing her arm from falling between the bed and the wall. C. Record review The 7/5/25 fall risk assessment documented that Resident #8 was at a high risk for falls. Resident #8’s fall care plan, initiated 10/1/24, identified that the resident was at high risk for falls. Pertinent interventions included non-skid socks, a call light within reach, the bed in the lowest position, the fall mat in front of the bed and staff were to offer assistance with ADLs before and after meals. A progress note, dated 5/27/25, documented interventions for fall included a floor mat at bedside as the resident allows/tolerates when the resident was lying in bed, non-skid footwear when not in bed, when possible, non-skid socks when not wearing footwear, when possible or as tolerated by the resident, bed in a low position when in bed, positioning wedges for tactile boundaries, an anti-rollback device on the wheelchair, and check and change before and after meals and during rounds at night. Fall incident on 7/1/25 - unwitnessed On 7/1/25, the interdisciplinary team (IDT) progress note documented that Resident #8 was found on the floor, lying in front of the bed with her head towards the foot of the bed. The resident was lying on the floor with her head on a pillow and covered with a blanket. The resident declined to wear non-skid socks. A floor mat was in front of the bed. The plan is to replace the resident’s call light with a bump call light. Fall incident on 7/5/25 - unwitnessed A post-fall note, dated 7/5/25, documented the nurse went into Resident #8’s room as the roommates' call light was on and the resident was found lying on the floor on her right side. A fall mat was in place, the bed was in lowest position and the call light was within reach. The resident was found without non-skid socks on, as the resident wore non-skid slippers during the day, but had them off as she was in bed and positioning wedges for tactile boundaries were not in place. The fall assessment was completed and the resident was scored at high risk for falls. D. Additional staff interviews Registered nurse (RN) #1 was interviewed on 8/7/25 at 4:26 p.m. RN #1 said Resident #8 had a history of falls. She said Interventions used for the resident were the floor mat at bedside and the bed in the lowest position. She said she did not know about the use of the tactile pillow as an intervention for Resident #8. RN #1 was interviewed a second time on 8/7/25 at 4:39 p.m. RN #1 said she had inquired what the tactile pillow intervention was for Resident #8, and she said it was a pillow that was put at the edge of the resident’s bed so she could feel it and know where the bed boundary was. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON and the nurse consultant were interviewed on 8/11/25 at 2:40 p.m. The DON said the facility used a fall assessment to determine the residents’ risk for falls. The DON reviewed Resident #8’s electronic medical record (EMR) and confirmed the resident was at high risk for falls. She said the resident had experienced falls. She said current interventions were to place the resident’s bed in the lowest position and ensure the resident’s call light was within reach. The DON said the interdisciplinary team (IDT), consisted of herself, the NHA, the SSD, the AD, and the physical/occupational therapist and the IDT was the staff involved with reviewing the fall evaluation post-fall incident. IV. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, history of transient ischemic attack (a brief and temporary interruption of blood flow to the brain) and history of falling. The 8/2/25 nursing admission assessment revealed the resident was confused and had short-term and long-term memory problems. She required assistance from staff for most ADLs and used a wheelchair. The nursing admission assessment indicated the resident had a history of frequent falls. B. Observations On 8/6/25 at 10:58 a.m. Resident #11 was attempting to self-propel in her wheelchair through the common area. CNA #1 transported the resident to the nurses’ station in her wheelchair. There were no foot pedals attached to the resident’s wheelchair, which caused the resident to hold her legs and feet up and off of the ground. -Other staff members were in the vicinity; however, no staff members intervened to ensure Resident #11 was not transported in her wheelchair without foot pedals. On 8/6/25 at 11:06 a.m. Resident #11 was again attempting to self-propel in her wheelchair near the nurses’ station. CNA #2 assisted the resident to her room and then to the television (TV) in the common area. There were no foot pedals attached to the resident’s wheelchair, which caused the resident to hold her legs and feet up and off of the ground. -Other staff members were in the vicinity; however, no staff members intervened to ensure Resident #11 was not transported in her wheelchair without foot pedals. On 8/6/25 at 11:37 a.m. Resident #11 was transported to the bathroom from the common area in her wheelchair. CNA #2 told the resident to lift her feet up. There were no foot pedals attached to the resident’s wheelchair, which caused the resident to hold her legs and feet up and off of the ground. C. Record review The fall assessment, dated 8/1/25, revealed Resident #11 was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #11’s care plan, initiated 8/4/25, identified Resident #11 was a fall risk. Interventions included utilizing a fall mat while the resident was in bed, keeping the bed in the low position and keeping the call light and frequently used items in reach. -However, the fall care plan failed to include an intervention to ensure Resident #11’s foot pedals were in place when she was being transported in her wheelchair in order to prevent potential falls. D. Staff interviews The director of rehabilitation (DOR) was interviewed on 8/11/25 at 1:05 p.m. The DOR said that not every resident utilized wheelchair foot pedals due to the facility’s goal to increase mobility. He said the residents’ feet should not dangle from the wheelchair or drag across the floor when staff were transporting the resident in order to prevent the wheelchair from tipping over. The DOR said each resident was fit to a wheelchair for proper fit and should have foot pedals in their room. The DON and the nurse consultant were interviewed on 8/11/25 at 2:40 p.m. The DON said a majority of the residents without wheelchair foot pedals had the ability to self-propel in their wheelchairs. She said there were foot pedals available for each wheelchair. The DON and the nurse consultant were unclear as to what was best practice for utilizing foot pedals during transport. The nurse consultant said the residents might fall trying to get out of their wheelchairs if foot pedals were attached to their wheelchairs. E. Facility follow-up On 8/12/25 at 4:52 p.m. (after the survey exit) the NHA provided an update regarding Resident #11’s care plan that documented the resident self-propelled safely without pedals and using them could hinder her mobility. -However, the care plan continued to fail to include an intervention for staff to ensure Resident #11’s foot pedals were in place when she was being transported by staff.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received proper respiratory treatment and care for two (#9 and #16) of the three residents reviewed for oxygen use out of 21 sample residents.Specifically, the facility failed to:-Ensure Resident #9 and #16 did not run out of oxygen in their portable oxygen tanks; and,-Ensure staff used the appropriate personal protective equipment (PPE) when filling residents' portable oxygen tanks.Findings include: I. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD - blocks air flow and makes it difficult to breathe), lower respiratory infection (infection in lower airways of the lungs) and chronic respiratory failure with hypoxia (lungs are unable to oxygenate the blood adequately). The 5/7/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required assistance with activities of daily living (ADL). The MDS assessment revealed the resident required oxygen use. B. Observations On 8/6/25 the following observations were made: At 11:00 a.m. Resident #9 was sitting in her wheelchair with oxygen on and engaged in an adult diamond art kit. At 12:08 p.m. Resident #9 called out for certified nurse aide (CNA) #1 and asked her to check her portable oxygen tank level. At 12:10 p.m. CNA#1 walked over to Resident #9 and pulled her oxygen tank out of its carrying case. CNA #1 checked the oxygen tank level and found the portable oxygen tank to be empty. Resident #9 said she did not feel oxygen coming out of the nasal cannula in her nose. CNA #1 went to fill the oxygen tank. C. Record review The oxygen care plan, initiated 3/10/25, identified that the Resident #9 was on supplemental oxygen related to the diagnosis of COPD. The resident was to receive oxygen via nasal cannula continuously at 2 liters per minute (LPM). Pertinent interventions included ensuring the resident received oxygen as ordered. -The care plan did not indicate how often staff were to check the resident’s portable oxygen tank to ensure that it was full. Review of Resident #9’s August 2025 CPO revealed a physician’s order for continuous (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen at 2 LPM via nasal cannula. II. Resident #16 A. Resident status Resident #16, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 CPO, diagnoses included epilepsy (seizures), prior stroke, thyroid disease, anxiety, COPD and depression. According to the 7/16/25 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required substantial/maximal assistance to toilet transfer. The MDS assessment indicated the resident used oxygen. B. Observations and staff interview On 8/6/25 at approximately 1:15 p.m., CNA #3 checked Resident #16’s portable oxygen tank and found it to be empty, as indicated by a steady red light. CNA #3 appeared surprised and said the oxygen tank should not have been empty already, as she had refilled it earlier that morning and expected it to still be full. She said she suspected a possible malfunction with the tank. She said earlier that morning, immediately after refilling it, she observed the oxygen tank’s dial light spinning in circles, which was abnormal. She said the oxygen tank might be broken, which could explain both the spinning dial movement and the oxygen tank being empty that early. C. Record review The oxygen care plan, revised 5/6/25, identified Resident #16 used oxygen. The resident was dependent on oxygen therapy and received 2 LPM via nasal cannula at night. The resident’s goal was to have no signs or symptoms of poor oxygen absorption or sleeping issues with oxygen use at night. Interventions included ensuring the resident's oxygen tubing was long enough for the resident to move around, encouraging her to wear the oxygen and giving oxygen as ordered and reporting any issues to the nurse or physician if the resident had any issues with oxygen levels. Review of Resident #16’s August 2025 CPO revealed a physician’s order for continuous oxygen via nasal cannula at 2 LPM. III. Staff interview The DON was interviewed on 8/11/25 at 8:06 p.m. The DON said she expected residents’ portable oxygen tanks to be filled before meals and after meals. She said the night shift staff filled the oxygen tanks before residents went to bed and in the morning as well. The DON said after being notified that Resident #9 and Resident #16’s portable oxygen tanks were empty, she had put a plan in place (during the survey) to ensure the oxygen tanks were checked on a more frequent basis. The DON said Resident #16’s oxygen tank may have been broken as she had heard it was spinning and it may have not been reading correctly. The DON said she would talk with the respiratory equipment provider and provide Resident #16 with a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new portable oxygen tank if the old one was faulty. The DON said when the portable oxygen tanks were filled, the staff were to wear the appropriate PPE, which included an apron, gloves and a face shield. IV. Facility follow-up The DON provided a notebook on 8/7/25 at approximately 11:00 a.m. with an audit log. The log included all residents who had oxygen orders. The log indicated the facility began oxygen audits to ensure oxygen tanks were checked at the start of the shift and every two hours. The audit log indicated if the oxygen tanks were less than a quarter full, the oxygen tank would be filled immediately. The new process indicated if the oxygen tanks were found empty, the charge nurse should be notified.

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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 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review and interviews, the facility failed to ensure menus met the resident's nutritional needs.Specifically, the facility failed to ensure residents were provided adequate food to ensure they were not hungry after meals and in between meals. Findings include:I. Facility policy and procedure The Menu Planning and Requirements policy, dated 2020, was provided by the nursing home administrator (NHA) on 8/11/25 at 12:33 p.m. It revealed in pertinent part, Menus are planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served, (based on age, gender, physical activity, and state health), in accordance with the Dietary Reference Intakes/Recommended Dietary Allowances as issued by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, unless otherwise contraindicated by medical conditions and needs. Menus are planned in advanced and are varied for the same day of consecutive weeks. Cycle menus are to be planned for a minimum of one week or based upon specific state regulations.II. Resident group interviewA group interview was conducted on 8/7/25 at 2:00 p.m. with five residents (#18, #19, #20, #21 and #22) who were identified by the facility and assessment as interviewable. The residents said the following: -The meals did not always fill them up; and, -They were hungry when the meals were over, because they did not receive enough food at their meals. -Resident #19 said she was unable to eat any of the snacks which were provided because she did not have teeth. III. Menu extensionsThe menu extensions for the week of 8/6/25 to 8/13/25 were provided by the NHA on 8/7/25 at 1:40 p.m The extensions revealed the following:The 8/6/25 menu extensions revealed the following menu items and portion sizes for dinner:-One breast, lemon herb chicken;-One cup garden salad;-Fresh baked roll; and,-Peanut butter cookie.-The menu extensions did not indicate the size of the chicken breast to be served. The menu caloric needs for 8/6/25 revealed the menu provided 1537 calories for the day.The 8/7/25 menu extensions revealed the following menu items and portion sizes for dinner: showed the following:-Chicken strawberry salad; -A bread stick; and, -A slice of pie slice.-The menu extensions did not indicate how much chicken strawberry salad or pie to serve to each resident. IV. ObservationsOn 8/6/25 at 5:15 p.m. the evening tray line was observed. The residents were served a chicken breast which was approximately three ounces, a biscuit, eight ounce (oz) garden salad and a peanut butter cookie. -The menu extensions indicated the residents were to receive a dinner roll and not a biscuit (see extensions above).On 8/7/25 at 5:15 p.m., the evening meal was observed. The residents were served three oz of chicken strips, iceberg garden mix salad served with tongs, a two oz scoop of strawberries, a breadstick and a slice of pie which was approximately one inch thick.V. Staff interviewsThe registered dietitian (RD) was interviewed on 8/6/25 at 5:30 p.m. The RD said the facility had menu extensions which were to be followed. The RD said she has changed the menu and extensions when residents did not like an entree. She said she reviewed the menus to ensure they met the needs of the residents. She said that she kept their daily calorie intake for the meals between 1700 and 1800 with room for snacks. -However, the extensions revealed the total calories provided on 8/6/25 was 1537 calories, which was below what the RD recommended for daily caloric intake (see menu extensions above). She said if a resident was losing weight then the protein pudding was utilized and also the resident was assessed for health shakes. The RD said that snacks were always available if residents were hungry. She said there were rice crispies, cheese crackers and various other snack items.The cook was interviewed on 8/7/25 at 5:15 p.m. The cook said he was not aware how the pie was cut and into how many portions. The cook agreed the pieces were small.