STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12905 Based on observations, interviews and record review, the facility failed to honor choices for five (#106, #1, #24, #36 and #20) of seven residents reviewed out of 30 sample residents. Specifically, the facility failed to honor choices for: -Resident #106 regarding bathing and food preferences; -Resident #1 regarding bathing; -Resident #24 regarding food preferences and family visits; -Resident #36 regarding food preferences; and, -Resident #20 regarding food preferences. Findings include: I. Facility policies and procedures The Resident Rights Under Federal Law policy, revised 3/1/18, was provided by the nursing home administrator (NHA) on the afternoon of 4/27/21 in response to requests for a policy regarding choices. The Resident Rights policy included the following purposes and practice standards: To incorporate the patient's goals, preferences, and choices into care. -To recognize each patient's individuality as well as honor and value his/her input. -To protect and promote the rights of the patient. Review these rights with the patient/resident representative on admission and at least annually or as often as needed. -Present Resident Rights related in-services to social work employees and all other employees on a regular basis. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Help the patient/resident representative understand and exercise his or her rights as needed. -Inform the patient of his/her obligation in the care process. -Review one to two resident rights each month during Resident Council meetings. -Staff will be in-serviced on Resident Rights at orientation and annually thereafter. II. Resident #106 A. Resident status Resident #106, age 74, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included Parkinson's disease and unspecified abnormalities of gait and mobility. According to the 4/10/21 admission minimum data set MDS assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. No mood or behavioral symptoms were documented. He was dependent for bathing. It was very important to him to choose between a bed bath, tub bath or shower. He had range of motion limitations to his upper and lower extremities. B. Resident interviews and observations The resident was interviewed initially on 4/21/21 at 5:06 p.m. He resided on the 100 hall, which was designated for residents on 14-day observation after admission for Covid-19 precautions. He was bedbound, lying on his back. He said he had not received a bath or shower, I can't get showers, and had received only bed baths since his admission. His hair was greasy and disheveled and his fingernails were dirty with brown matter underneath. -He was eating dinner from a tray on his overbed table. He said he liked the cole slaw, had eaten it all, and asked for seconds but the staff told him dietary said they had run out. Observations revealed the resident moved off the 100 hall to the 400 hall on 4/22/21. The resident was interviewed again on 4/26/21 at 8:22 a.m. He was lying in bed and had just received his breakfast tray. He said he would get his shower tomorrow; at least he knew when. -He looked at his breakfast tray and said, I won't eat any of this . They call this a banana, and pointed to half of an overripe, brown spotted banana with a black, withered stem. -He said he liked potatoes and bacon. That would be wonderful. On a daily basis. -The MDS coordinator entered his room to visit with him, and told him he would need to take up his breakfast preferences with dietary; They come around and talk to residents. She lifted the cover from his breakfast plate and revealed French toast, and the resident said he would not eat it. There were also two bowls of oatmeal on his breakfast tray (all sweet items). The MDS coordinator said she would take care of breakfast this morning, indicating she would follow up with dietary. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A few minutes later, the resident's breakfast tray had been removed, nothing but drinks were on his overbed table, and he had a copy of the monthly menu on his chest. He said evidently potatoes and bacon were not on the menu. (Cross-reference F692 nutrition/hydration and F804 palatable foods.) C. Record review 1. Bathing The resident's ADL function care plan, initiated 4/5/21 and revised 4/21/21, documented he required assistance or was dependent (not personalized) for ADL care in bathing and grooming related to adult failure to thrive, Parkinson's disease and age related physical debility. Interventions included Provide resident total assist of 1-2 staff for bathing. -The care plan regarding preferences documented on 4/9/21, It is important for me to receive a bath. Bathing frequency and specific type of bath/shower were not documented on the care plan. There was no documentation of an additional resident interview (other than the MDS above) regarding his preferences for types of baths/showers, number per week or days and times. Review of the resident's bath records for April 2021 revealed he had received five bed baths out of 30 opportunities, and no tub baths or showers. 2. Food preferences The resident's nutrition care plan, initiated 4/8/21 and revised 4/26/21, identified nutritional risk related to Parkinson's and adult failure to thrive, on regular textures, eats independently and weight stable. (This was inaccurate - cross reference F692 nutrition/hydration and F677 ADLs.) Interventions included: Honor food preferences within meal plan . Offer alternate choices as needed. The resident's food preferences were not listed on his care plan. Review of the resident's undated food preferences list, printed out and provided by the regional dietary consultant and dietary manager on 4/27/21 at 10:30 a.m. (see interview below), revealed no likes were documented for Resident #106. The only dislikes documented were 25 varieties of eggs (scrambled, fried, omelets, etc.). D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/26/21 at 10:38 a.m. She said there were not enough staff, and added, I'm the bath aide and I'm pulled to the floor. Residents are angry because they have to wait. Those who need two-person assistance are waiting too long for toilet assistance and showers. (Resident #106) hasn't had a shower yet. He was supposed to get one today but I'm pulled to the floor. He was supposed to be getting bed baths on the (100 hall/observation) unit. (Cross-reference F725 sufficient nursing staffing.) (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse aide (NA) #1 was interviewed on 4/26/21 at 10:15 a.m. She worked on the 100/observation hall. Regarding baths/showers she said, Residents are given bed baths back here or use wipes to clean themselves. They're not offered a shower/bath option that I know of, probably because they don't want residents going off the unit. -She said she had received food complaints from residents Sometimes, and that Resident #106 likes bacon . he would order bacon every morning. The director of nursing (DON) was interviewed on the morning of 4/27/21. She said the resident had gotten a whirlpool tub bath early the morning of 4/27/21. She said residents on the 100 hall received bed baths only, as that was their guidance from corporate for residents not to leave the observation/quarantine area. She said they were trying to get approval from corporate to provide showers per the preference of the residents who resided on the 100 hall. The dietary manager and regional dietary consultant were interviewed on 4/27/21 at 10:30 a.m. She said she was unable to provide potatoes and bacon for Resident #106 per his request that morning. She said the nursing home administrator (NHA) had told her yesterday (4/26/21) that if residents had not had significant weight loss and their food requests were not on the menu, they were not to provide it due to budget concerns. If we provide for one, then everyone else will want it too. The facility failed to honor choices for Resident #106 regarding bathing and food preferences. III. Resident #1 A. Resident status Resident #1, age 86, was admitted on [DATE]. Diagnoses according to the April 2021 CPO included displaced humerus fracture, hemiplegia affecting dominant side, cerebral infarction and need for assistance with personal care. According to the 1/9/21 MDS assessment, the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. Mood and behavior indicators documented trouble sleeping and poor appetite, with no behavioral symptoms or care rejection. It was very important to her to choose the type of bath or shower. She needed extensive assistance with ADLs, and physical help in part of the bathing activity. B. Resident interview The resident was interviewed on 4/21/21 at 4:30 p.m. She said she would prefer showers or baths three times a week but they don't have enough staff. I haven't told them. I know I wouldn't get it. (Cross-reference F725 sufficient nursing staffing.) C. Record review The resident's ADL function care plan, initiated 10/2/2019 and revised 3/25/21, identified she needed assistance with ADL care in bathing due to limited mobility, CVA (stroke) with left-sided weakness, dysphagia and right humeral fracture. Interventions included, Provide (Resident #1) with extensive assist of 1 for bathing. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preferences regarding bathing frequency and type were not included in the care plan. Review of the resident's ADL Record for the past three months revealed the resident was receiving baths once a week or less often. -During February 2021 she received four tub baths (on 2/2, 2/5, 2/9 and 2/16/21). She refused baths on 2/19, 2/23, 2/26 and 2/27/21. -During March 2021 she received four tub baths on 3/2, 3/9, 3/16 and 3/23/21, and refused on 3/26/21. -During April 2021 she received two tub baths on 4/6 and 4/27/21, and refused on 4/20/21. There were no corresponding nursing notes regarding the resident's refusals and no evidence that baths were re-offered the following day, except on 2/26-2/27/21. There was no documentation the resident was interviewed regarding her bathing preferences. D. The DON was interviewed on the afternoon of 4/27/21. She reviewed Resident #1's bath records. She said it could not be right that the resident had received so few baths and said she would check to see if there was additional documentation. As of 4/30/21, no further documentation was provided. The facility failed to honor choices for Resident #1 regarding bathing. IV. Resident #24 A. Resident status Resident #24, age 93, was admitted on [DATE]. Diagnoses on the April 2021 CPO included chronic kidney disease and atherosclerotic heart disease. According to the 3/10/21 MDS assessment, the resident had severe cognitive impairment with a BIMS score of eight out of 15. Mood and behavior symptoms documented little interest or pleasure in doing things, and care rejection one to three days during the review period. He required extensive assistance with ADLs, and setup only for eating. He received hospice care since admission. B. Observations and family interview The resident was interviewed on 4/21/21 at 2:39 p.m. He said, I'm weak as all get-out and they don't feed me enough. I'd like to eat better . I haven't put on any weight since I've been here. I'm shrinking. The resident said he would like to eat lots of ice cream. Vanilla. Bananas, peaches, apples, oranges, to put something on your gut and have something to eat that'll fill you up because I have a hollow place in my stomach that tells me I haven't eaten enough . Anything to give me strength. I need strength. On 4/21/21 at 3:05 p.m. Resident #24 was sleeping, holding a small cup of ice cream. The CNA said they did not have vanilla ice cream so she brought him chocolate. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's family member was interviewed on 4/22/21 at 8:45 a.m. She said she had been unable to visit with Resident #24 except through the window until he gets his second (COVID-19) vaccine next week. She said when he lived on the 100 hall he was by the window, but Communication through the window has been hard because he's on the opposite side of room and his roommate is by the window. They haven't mentioned compassionate care visits, although the resident was bedbound and on hospice. C. Record review There was no documentation of family visits in the resident's medical record, including the care plan. The resident's 3/8/21 nutritional assessment documented he felt he had a good appetite depending on what was served. He was informed of snacks available between meals. Goal is comfort focused. Recommend honoring food preferences, offer snacks between meals. The resident's nutrition care plan, initiated 3/10/21 and revised 4/2/21, documented unavoidable weight loss related to end stage disease, comfort focused, food preferences will be honored. Interventions included, Honor food preferences within meal plan . Offer snacks. The resident's meal preferences and favorites were not documented in the care plan. The resident's likes/dislikes list included 19 dislikes, four special requests and no likes. Dislikes included 19 entrees. Special requests included only beverages: coffee, cranberry juice and lemonade (listed twice). Review of the resident's weight records revealed he had a 6.67% weight loss from 3/3/21 to 4/1/21, via mechanical lift, standing and bath. Weights were documented as follows: 3/3/21 - 165 lbs., 3/4/21 - 161.8 lbs. , 3/11/21 - 163.4 lbs., and 4/1/21 - 154.2 lbs. D. Staff interviews The dietary manager was interviewed on 4/27/21 at 11 a.m. She said, We don't serve a lot of ice cream but we do have chocolate ice cream and sherbet. I only order vanilla when it's on the menu. That's a corporate budget thing. I'll bring it up to (the registered dietitian) now . On Monday (5/3/21) we'll start asking residents for preferences and menu choices daily; right now we're doing it every 2 weeks. The DON was interviewed on the afternoon of 4/26/21. She said she did not realize Resident #24's family had not been invited to the facility for compassionate care visits, and Resident #24 would certainly qualify and benefit from it. She said she would call and invite them. The facility failed to honor choices for Resident #24 regarding food preferences and compassionate care family visits. 26246 V. Resident #20 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #20, age 72, admitted on [DATE]. According to the April 2021 CPO, diagnoses included osteoporosis, muscle weakness, history of falls and dysphagia (difficulty swallowing). According to the 3/3/21 MDS assessment, the resident was cognitively intact with a BIMS of 11 out of 15. She had moods to include poor appetite or overeating. She was independent with eating not requiring any staff help or oversight. She was 64 inches and 80 pounds. She was assessed to have weight loss of five percent or more in the last month or 10 percent or more in the last six months and not on a physician-prescribed weight loss regimen. B. Resident interview The resident was interviewed on 4/21/21 at 11:08 a.m. she said that she was not offered a choice of what she would like to eat for breakfast, lunch or dinner. She said, You get what they bring you. No one offers any choices. She said no one came in to talk to her about the food choices for each meal each day and did not offer her any alternate food choices. She said she was supposed to get scrambled eggs every day at breakfast but that it was not happening. C. Record review A 10/19/2020 admission nutritional assessment documented the resident's height was 64 inches and weighed 97 pounds and her body mass index (BMI) was 16.6. Her calculated total daily nutritional needs were: 1355 total calories, 44 grams of protein and 1322 fluids. She was documented as underweight based on her BMI and that the weight loss was unintended. She had a history of health decline and poor appetite. She dined in her room. She had no chewing or swallowing problems noted. Her nutritional plan was to honor her preferences and comfort focused care and that weight loss may be unexpected and unavoidable. She was to be offered snacks and hydration between meals as desired.(Cross reference F692, failure to maintain acceptable parameters of nutritional status). A nutritional care plan initiated 3/1/21with a target date of 6/1/21 identified the resident at risk related to low body weight, weight loss and decreased oral intake. The goal was she would remain comfortable during the end of life and food preferences would be honored. Interventions included hot sauce would be provided by dietary, encourage the resident to chew and swallow each bite, provide diet as ordered, offer snacks between meals and provide house supplement frozen treat three times a day as ordered. A nutrition note dated 3/12/21 documented the resident's weight was fluctuating between 79-82 pounds since 1/19/21 with a significant weight loss of 8.7 percent in 90 days. She ate her meals in her room. The resident would be provided with supportive and nutrition care to honor her preferences and to provide balanced and healthy menu options. The goal was comfort during the end of life. A care plan meeting dated 4/20/21 documented in part the resident did not like many foods and the family would help to supplement what the facility offered by bringing her fast food. Her ill- fitting dentures were discussed and she said she did fine without them. She was being offered a magic cup (a nutritional supplement) and would like to get them three times a day from twice a day. She said she would like to get scrambled eggs every day and the facility would accommodate that for her (see resident's interview). (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's food preference sheet dated 4/27/21 revealed the resident received a house supplement cup every day at breakfast, lunch and dinner. Her dislikes listed included: fish/seafood and gravy. Under the Likes section was documented-none. In the between meal snacks was documented-none. The resident's meals were observed at random times during the survey. Each time the resident said she was not given a choice what to eat. The facility failed to honor choices for Resident #20 regarding food preferences. D. Staff interviews CNA #10 was interviewed on 4/27/21 at 12:45 p.m. She said the resident was particular about what she ate and liked to eat snacks like her cherry pie and drink her soda. She said the resident always ate in her room in bed. She said she was not responsible for taking the resident's food orders and just served them their tray when it arrived. The DM was interviewed on 4/27/21 at 6:07 p.m. She said she was the one responsible for obtaining each resident food choice and that there were only two meal items to choose from. She said she would do this two to three weeks in advance and then input the choices into the computer system. She said residents were not given a choice for breakfast and that a lot of breakfast items had been removed from the menu. She said there was not a choice for an alternative breakfast item. She said she knew that Resident #20 chose to have scrambled eggs every morning but that they had to follow the corporate menu. She said the resident's meal ticket should say scrambled eggs on it but that it did not. She said she had tried to obtain her food preferences but all she wanted was fast food and. She said that as far as she knew hospice was supposed to reach out to the family to bring in fast food for her once in a while. She agreed that residents should get what they want to eat but that it just was not possible. The DON was interviewed on 4/27/21 at 5:00 p.m. she said that they had a contract company for their dietary department. She said that the dietary menus had two choices for the main meal and two alternates. She said only the two main entrees were prepared. She said the night CNAs would go to the residents and ask them what they want for the next day. She said some food items that residents ask for are not on the menu. She said staff should be offering the resident a choice of which meal item they want. The RD was interviewed on 4/27/21 at 10:40 a.m. she said that the dietary department had to follow the company menu. She said if a resident did not like the meal that was brought to them they would try and offer another similar item but could not provide certain items. She said that families were welcome to bring in food that the resident would like. She said they had to remain within their budget. She said food preferences should matter within the ability of their budget.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 31797 Based on record review and interviews, the facility failed to provide thorough and complete beneficiary notices to the resident's representative for one (#11) of three residents reviewed for beneficiary notices out of 30 sample residents. Specifically, the facility failed to provide, in writing, the items and services that the facility offered and for which the resident may be charged, including the amount of charges for those services. Findings include: I. Facility policy and procedures The SNF (skilled nursing facility) Advanced Beneficiary Notice (SNFABN) for Medicare A, SNF ABN CMS-10055 policy, revised 10/30/2020, was provided by the business office manager (BOM) on 4/26/21 at 11:30 a.m. It documented the SNF lists the care that it believes may not or won't be covered by Medicare. The description must be written in plain language that the beneficiary can understand. The care can be listed as inpatient stay at this facility for example. SNF must give the applicable Medicare coverage guideline (s) and a brief explanation of why the beneficiary's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable beneficiary to understand why Medicare may deny payment. Attach the Center's current room and service price list form. SNF enters the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimates total cost or a daily, per item or per service cost estimate. SNF must make a good faith effort to insert a reasonable cost estimate for the care. II. Record review Resident #11's last covered day of Medicare Part A services ended 2/5/21. The resident remained in the facility. Both CMS 10123 and 10055 forms were provided and signed by the resident's representative on 2/3/21. Form 10123 was completed appropriately. However, the type of care and services, the reason Medicare may not pay for the services and the estimated cost of these services were not completed on the 10055 form. -Due to the incomplete information, the resident's representative was not provided all information in which to make an informed decision. III. Staff interviews The BOM was interviewed on 4/26/21 at 9:17 a.m. She said she had worked in the facility for the past two years. She said initially, she did not understand what NOMNC's (Notice of Medicare Non-Coverages) and SNF ABN's (Skilled Nursing Facility Advanced Beneficiary Notices) were, but she received some training and was comfortable completing these forms. She said she expected all forms to be completed in their entirety prior to being provided to the resident or their representative. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said Resident #11's paperwork was incomplete because the minimum data set coordinator (MDSC) was now the staff member who completed those 10055 forms. The BOM said she had not had enough time to train the MDSC on completing the paperwork yet. She said she accepted full responsibility for not training the MDSC on completing this required paperwork. The MDSC was interviewed on 4/26/21 at approximately 9:25 a.m. She said she had been completing the SNF ABN (Form 10055) paperwork for the past eight months. The nursing home administrator (NHA) was interviewed on 4/26/21 at approximately 3:45 p.m. He said the above notices should be fully completed before providing those forms to the resident or their representative.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26246 Based on resident, staff interviews and record review, the facility failed to ensure two (#36 and #6) of five residents reviewed for abuse out of 30 sample residents, were free from physical and verbal abuse. Resident #36 said in an interview on 4/21/21 that he was verbally abused by certified nurse aide (CNA) #4 about a month and a half ago. He said it made him feel not respected and he was shocked and angry. He said that nursing staff were aware but no one had come to talk to him about the issue. Resident #36 said that approximately two months ago he had heard angry yelling in his hallway and as he passed a resident room, he saw CNA #1 standing next to a resident who had his face down on his plate of food. Record review revealed that Resident #36 had a verbal interaction with CNA #4 on 3/7/21. There was no documentation found that the facility followed up on the matter. There was no documentation found regarding Resident #36's observation of the angry yelling involving CNA #1. Resident #6 said in an interview on 4/26/21 that he had been verbally and physically abused by CNA #1 and #6. He said CNA #1 had called him pathetic and had thrown him into bed one night. He said CNA #6 tried to pry open his two fingers that were frozen (contracted) on his left hand and it hurt him. He said that the interactions with both CNAs made him feel undignified, disrespected, and like he was being pushed around. He said he also felt angry and did not know how to defend himself. He said he did not say anything to anyone and did not like talking about it. He said he just wanted to forget about it. There was no documentation found to demonstrate that the facility further investigated the incident with Resident #6 and CNA #6. In addition, CNA #6 was allowed to continue working with residents after the facility was aware of Resident #6's abuse allegation. The facility's failures subjected Resident #36 and #6 to verbal and physical abuse by three CNAs assigned to provide care to vulnerable residents, and the potential for other facility residents to suffer abuse. Cross-reference F609, failure to report alleged allegations of abuse; and F610, failure to thoroughly and timely investigate allegations. Findings include: I. Facility policy and procedures (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The Abuse Prohibition policy, revised April 2021, was provided by the nursing home administrator (NHA) on 4/22/21 at 2:25 p.m. The policy documented in pertinent part, (The facility) prohibits abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter 'patient') property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The Center will implement an abuse prohibition program through the following: - Screening of potential hires; - Training of employees (both new employees and ongoing training for all employees); - Prevention of occurrences; - Identification of possible incidents or allegations which need investigation; - Investigation of incidents and allegations; - Protection of patients during investigations; and - Reporting of incidents, investigations, and Center response to the results of their investigations. II. Resident #36 A. Resident status Resident #36, less than [AGE] years of age, was admitted on [DATE]. According to the April 2021 computerized physicians orders (CPO), diagnoses included chronic obstructive pulmonary disorder (COPD), depressive disorder and anxiety. According to the 3/24/21 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. He had no documented moods or behaviors, and no rejection of care. He was dependent for bathing with no set up or physical help from staff. He was independent with locomotion per electric wheelchair. B. Resident interview Resident #36 was interviewed on 4/21/21 at 10:00 a.m. When discussing abuse, he said that he had a verbal altercation with CNA #4. He said that she had awakened him from a deep sleep and that she had rushed him to go and take a shower. He said this happened over a month ago. He said she was irritated with him and was rushing him to finish his shower and get dressed. He said he was angry and frustrated because of the way he was awakened and how he was being rushed. He said, in standing up for himself, CNA #4 became angry at him and yelled at him. She said she did not have to put up with his f-- s--, and had said s-- of a b--. He said she had cursed at him first and he then cursed back at her. He said it was loud enough that people outside of the shower room could have heard it. The resident said he was not afraid of her and that she was not giving him showers anymore. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident then said that a couple of months ago he had heard CNA #1 yelling in an angry tone as he wheeled past a room that was on the same hallway that he lived in. He said he saw CNA #1 standing next to a resident who had his face in his food. He said she looked at him as he went by. He said she had yelled so loud it could be heard down the hallway. He said that he had told the director of nursing (DON) about the incident but that no one ever got back to him about it. He said no one had come to talk to him about either of the incidents. C. Record review The resident's mood care plan, initiated 6/26/2020 and revised 11/9/2020, identified the resident exhibited or was at risk for distressed and/or fluctuating mood symptoms such as depression, sadness, anxiety and irritability related to his diagnoses. Interventions included to observe for signs and symptoms of worsening sadness, depression, anxiety and irritability, encourage him to seek staff support for distressed mood, have him refocus on something positive and allow him time for expression of feelings, provide empathy, encouragement and reassurance. A nurse note dated 3/7/21 documented in part that the resident was in the shower room with the bath aide (CNA #4) and was being very aggressive and attempting to swing at the CNA. The aide feared he would get more angry and physical so she asked him to leave to which he responded by calling her a b---, and multiple other insults. The resident was commonly rude to staff. A care plan initiated on 4/15/21 (more than a month later) identified the resident exhibited or had the potential to exhibit physical behaviors related to yelling at staff, using foul language and calling staff names. The interventions included: -Evaluate the nature and circumstances (triggers) of the physical behavior with the resident and/or resident representative, discuss findings with the resident and family members/caregivers and adjust care delivery appropriately. -Resident to seek staff support for distressed mood, explain all care, including procedures (one step at a time) and the reason for performing the care before initiating. -If resident becomes combative or resistive, postpone the care/activity and allow time for him/her to regain composure and provide resident with opportunities for choices during care/activities to provide a sense of control. D. Staff interviews Registered nurse (RN) #1 was interviewed on 4/21/21 at 1:59 p.m. She said that she had not seen any staff yell at residents. She said she had witnessed residents being verbally abusive towards staff by yelling and swearing and that she had heard staff asking residents to please not speak in that manner. She said if a resident continued to be abusive staff should just walk away. The NHA and DON were informed on 4/22/21 at 3:00 p.m. about Resident #36's report of verbal abuse, both directed against him and witnessed by him. They were also informed that the resident said he had reported the verbal abuse (loud yelling) that he had witnessed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA said that staff told him that Resident #36 had made aggressive comments and cursed at them and that he had talked to the resident about his actions. He said the resident became angry at times depending on the situation and then he would calm down. He said he had heard from another staff member that Resident #36 was the one who cursed at CNA #4. The DON said CNA #4 wanted to give the resident a shower and he wanted a different shower time. The DON said Resident #36 had reported to her that he had heard staff raising their voices towards someone who needed help across the hall from him. He told her he went out to the hall to see what the problem was and one of the CNAs told him they were dealing with the issue and that he did not need to be there. She said she did not remember when this happened but that the resident identified the CNA as CNA #1. The NHA said he had not heard anything about CNA #1 yelling at residents and that he talked to Resident #36 on a regular basis. Both the NHA and DON said they had not done an investigation for either of the incidents. The DON said CNA #4 did not work with the resident anymore. She said she had talked to CNA #1 about the yelling allegation but did not document it or do an investigation. The NHA said he would look into this matter right away. On 4/22/21 at 5:00 p.m. the NHA reported that he had suspended CNA #1 and CNA #4 pending the outcome of the abuse investigation to ensure Resident #36 and all other residents were kept safe. CNA #10 was interviewed on 4/26/21 at 2:22 p.m. She said Resident #36 had mentioned to her that a lot of the CNAs got irritated with him but she did not know what that was about. She said she had never seen CNA #6 do anything bad towards a resident. She said that CNA #6 did tell her today that Resident #6 (see abuse allegation below) had hit her with a washcloth. She said if she saw anything like that she would report it right away. Licensed practical nurse (LPN) #2 was interviewed on 4/26/21 at 12:10 p.m. She said if she was aware of any abuse she would first make sure the resident was safe, remove the perpetrator and report it to the DON and NHA right away. She said that she had not witnessed any type of abuse by staff towards residents. She said she had heard residents say before that they do not like a certain staff member and the way they did things. She said if she heard a staff member sounding frustrated, she would encourage them to take a break. She said that Resident #36 had told her about general complaints with staff members like having to wait a long time for his call light to be answered but he had not mentioned abuse to her. She said that Resident #36 could become verbally harsh depending on his mood. E. Facility investigation and follow-up The NHA said he reported Resident #36's allegations of verbal abuse to the State Agency on 4/22/21 during the survey. The facility was aware before 4/22/21 (see interviews above) that the resident had reported a second allegation of verbal abuse by CNA #1. In addition, the facility was aware of the verbal abuse by CNA #4 on 3/7/21. These allegations had not been reported timely to the State Agency (Cross-reference F609, failure to report alleged violations.) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An investigation report regarding verbal abuse for Resident #36 and witnessed verbal abuse, dated 4/22/21, was provided by the NHA on 4/26/21. The report documented the allegation was reported to the State Agency on 4/22/21 and to the police (no date or time specified). 1. Staff to resident verbal abuse The investigation revealed Resident #36 was interviewed as well as seven staff and 12 residents. The interviews did not have a documented date or time, or documentation of who conducted the interviews. The investigation documented in part the following: Resident #36's interview revealed CNA #4 entered his room in the afternoon when he was napping. She told him to get up, we ' ve got to take your shower, I ' ve got to go. The resident felt rushed. She said she would take his items to the shower room and come back to get him. When she returned she told him aren ' t you ready yet? When they got to the shower room he may have said something to her but he did not remember and then she responded: I don ' t have to take your f--- s---! He responded to her, F--- you b---! She responded with, get the f--- out of here! and then left the shower room. She then came back and said, I told you to get the f--- out of here! The resident stated he was not fearful, just angry. CNA #4's interview revealed that she entered the resident's room and told him it was time for his bath and that he ignored her. She then took his belongings to the shower room. When she returned she told the resident she was ready and the resident did not respond and she began to leave the room. The resident then said to her, God d--- it, I was sleeping. She said she told him she was sorry and asked him if he would rather not have a bath. He responded by telling her that she was not sorry. He then transferred himself to his chair and followed her to the shower room. He then began to take off his shirt and she went to assist him. He pulled his shirt out of her hands and said, God d--- it, I ' ll do it myself! The CNA then told him to put on his shorts and leave. He then responded to her, You don ' t talk to me that way you f--- b---! The CNA then responded, I ' m sick of your s---, just leave! A nurse interview documented she heard arguing behind the door of the shower room. Then the shower door opened and she heard CNA #4 tell the resident to leave the shower room. The resident said, you f--- b---, I need to wash off. Then CNA #4 said, I f--- told you to leave and left the shower room. CNA #4 then returned to the shower room, the resident was still there and CNA #4 said again, I f--- told you to leave. All 12 resident interviews denied any concerns with staff during their baths. The facility substantiated the verbal abuse towards Resident #36 by CNA #4. 2. Witnessed verbal abuse The investigation (provided by the NHA on 4/27/21 at 10:00 a.m.) revealed Resident #36 was interviewed along with four staff and 10 residents. The interviews did not have a documented date, time or name of the person interviewing. The investigation documented in part the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #36's interview revealed that he had heard loud yelling when going down the hall. He passed a room and saw a resident asleep on his tray. CNA #1 was standing in the room on the resident's side and looked at Resident #36 as he passed by the door. He did not hear any more yelling. He did not know who the resident was. He said he could not remember the time and that it was approximately a couple of months ago. CNA #1's interview revealed that she had never come across a resident asleep on their tray and that she had never yelled angrily at a resident. One of the 10 residents interviewed said that one morning she told a staff member that she was not ready to eat her breakfast just yet. She said the staff member told her she needed to eat now and she stood up for herself and told the staff member that she could say no and was told again, you have to eat. The resident said the staff person was not yelling, but had an elevated tone. The resident was unable to identify the staff person. A second resident interview revealed that the resident was standing at the end of the bed doing something and the housekeeper asked if he could move. The resident did not respond or move and the housekeeper said, Ok, I just won ' t clean your room today and left the room. He said he felt rushed. The NHA said (on 4/28/21 at 5:06 p.m.) that this investigation was still not completed and that they would be doing more interviews. He said he would provide follow up as it was completed. The NHA and DON were interviewed a second time on 4/27/21 at 7:34 p.m. before the conclusion of the survey. The NHA said that CNA #4 (alleged verbal abuse towards Resident #36) would remain on suspension until things could be sorted out with corporate guidance. He said he felt pretty certain that CNA #4 would be terminated. The NHA provided follow-up on 4/28/21 at 7:36 p.m. The allegation of CNA #4 verbally abusing Resident #36 was substantiated and CNA #4 was terminated. In addition, the nurse that wrote the progress note on 3/7/21 (above) was terminated. The report did not document follow-up on the additional allegations revealed by residents during the investigation, and the investigation was still incomplete. III. Resident #6 A. Resident status Resident #6, age 79, was admitted on [DATE]. According to the April 2021 CPO, diagnoses included Parkinson's disease, anxiety, major depressive disorder, obsessive compulsive disorder (OCD) and dementia. According to the 1/21/21 MDS assessment, the resident was cognitively intact with a BIMS of 13 out of 15. He was identified with moods of trouble concentrating on things such as reading the newspaper or watching television. He had no behaviors and did not reject care. He required extensive assistance for transfers, dressing, eating and toileting. He required limited assistance for personal care. He was totally dependent on bathing with one person assistance. He used a wheelchair or walker for ambulation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Resident interview Resident #6 was interviewed on 4/26/21 at 10:39 a.m. The resident shook his head and said his weekend was not good. He began to explain that CNA #6 had been rough with him when cutting his fingernails. He said she was also loud and got in his face telling him she had to clip his nails because they were long and dirty. He said she had an attitude that it had to be done right now and her way. He said she tried to pry open his middle fingers on his left hand that were frozen stiff and difficult to open. He said it was painful and he told her to stop and that she did not pay attention to him and continued trying to open his hand. The resident said this was not the first time someone had treated him badly. He said shortly after he moved to the facility there was an incident with CNA #1. He said she had told him he was pathetic and he could not understand why she said that to him. He said that she was assisting him to bed one night and that she was rushing him. He said he moved slower now due to his condition. He said that she had thrown him into bed and that he twisted his neck and his left arm. C. Record review (Cross-reference F610) There was no documentation or investigation found regarding the resident's allegation of verbal abuse by CNA #1. There was no documentation or investigation found regarding the resident's allegation of physical abuse by CNA #6. A care plan initiated 1/27/21 identified the resident stated it was important that he had the opportunity to engage in daily routines that were meaningful to his preferences. Interventions included that he liked his personal activities of daily living organized related to his OCD diagnosis. The resident had a tendency to mumble and speak continuously, one subject after another. He would benefit from accommodation for physical limitations by being transported in his wheelchair. When requested, staff were to assist him with items that he needed his hands for, and his left hand was clenched into a fist (contracture). A nurse note dated 3/14/21 documented in part the resident was found face down in his oatmeal asleep. He was then found at lunch face down on his plate asleep. D. Staff interviews CNA #10 was interviewed on 4/26/21 at 2:22 p.m. She said that Resident #6 did not have any behaviors and was usually very quiet. She said he was slow to do any task and that he did not like any of his personal things moved and liked things placed a certain way. The NHA and DON were informed on 4/26/21 at 11:14 a.m. about Resident #6's report of verbal and physical abuse by CNA #1 and CNA #6 (see resident interview above). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA said that he had just talked to the resident yesterday and asked him how he was feeling and if he had seen anyone talking or yelling loudly, and that he did not mention anything about how he felt. The DON said that there was an episode yesterday with Resident #6 and CNA #6 during a bath and that the resident had hit CNA #6 in the face with a washcloth. The DON did not initiate an investigation when she became aware of the situation. The NHA said he would follow up on this right away. On 4/26/21 at 2:20 p.m. the DON provided follow up and said that they had sent CNA #6 home on suspension. She said that she had asked CNA #6 what had happened, and CNA #6 said the resident had hit her in the face with a washcloth during his shower when she was clipping his nails. She said CNA #6 told her that she did try to open his fingers on his left hand because she thought his fingernails may be digging into his left hand. She said the resident said ow, and then she stopped and asked other staff to take over for her. E. Facility investigation and follow-up The NHA said he reported Resident #6's allegations of physical abuse by CNA #6 and physical and verbal abuse by CNA #1 to the State Agency on 4/26/21. (See Resident #6's interview above.) The investigation revealed Resident #6 was interviewed as well as three staff and five residents. The interviews did not have documented dates, times or names of interviewers. The investigation documented in part the following: Resident #6's interview revealed that he was describing different episodes. First he described he was being kept from eating his toast and then that he was rushed in the shower. He said that a staff person had told him he was pathetic, and that it had happened yesterday. He said she went to clean them (his nails) and that they needed to be done a certain way. He said it was not hurting until two fingers, when she pulled them open it hurt, and he told her it hurt a couple of times. He said she let go after he smacked her. He said he did not know why he hit her and that he felt inferior. CNA #6's interview revealed she had bathed the resident and shaved him. She said she was cleaning his fingernails and did his right hand with no problem. She said when she went to move a finger away from his palm on his left hand so she could do his nails he said Ow! She said she immediately let go. She said the resident had grabbed a wet washcloth and smacked her in the eye and called her a f--- b---. She said she got help and had other staff dry and lotion him and take him back to his room. CNA #11's interview revealed she was not there when it happened and that CNA #6 asked for help with the resident. She said CNA #6 told them the resident had hit her with a washcloth. She said the resident was yelling at CNA #6, you're hurting me, you're not listening to me. Registered nurse (RN) #2's interview revealed she went into the shower room and the resident was very angry. She said they were trying to calm him down. She asked the resident what happened and he said that they were not being patient with him and they were rushing him. He said during the time they were drying him and putting lotion on him they were hurting him. She said the staff had stopped and talked with him until he allowed them to resume. She said all the staff were being very gentle with him. She said she did not feel the resident was fearful but angry about being rushed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/27/21 at 7:35 p.m. the NHA said that the investigation regarding allegations of abuse by CNA#1 was still in process and he would provide follow up when it was completed. F. Further observations and interviews Observations on 4/27/21 at 8:35 a.m. revealed that CNA #6 (involved in a physical abuse allegation with Resident #6 on 4/25/21, and suspended on 4/26/21) was back in the facility and working with residents providing baths. On 4/27/21 at 9:00 a.m. the NHA was asked why CNA #6 was back and working with residents. He said that he was not able to substantiate the allegation based on Resident #6's interview. He said the resident was not making sense and confusing his stories. He said other resident and staff interviews revealed no concerns. He said CNA #6 would not be working with Resident #6 anymore. He was asked if CNA #6 had been given education prior to coming back to work and working with residents, and he said he had not started that yet and would get on that right away. The NHA and DON were interviewed a second time on 4/27/21 at 7:34 p.m. before the conclusion of the survey. They were asked about the follow up plan involving CNA #6 since they concluded Resident #6's allegation against her was unsubstantiated. The DON said that CNA #6 had been pulled from the floor this morning to begin additional training and education via computer modules, and then she was sent home. She said CNA #6 would be off of work for a few days while the investigation was resumed. The NHA was asked if there was also a plan to provide supervision and monitoring for CNA #6 before she returned to work at the facility on 4/27/21, and the NHA said he would put one into place. He said that a disciplinary write up would be placed in her employee file. The DON said they would be initiating a new investigation. The NHA said that he was still in the early stages of investigating Resident #6's allegations of abuse regarding CNA #1 and that she was still suspended. He said he still had to interview more staff and residents and contact his corporate office for guidance on how to proceed. He said after hearing of the second allegation against her, CNA #1 had resigned her employment. The NHA acknowledged that if staff were expressing stress and burnout it could be an indication for bigger problems and he wanted to ensure the residents felt safe. The NHA provided follow-up on 4/29/21 at 5:06 p.m. He said that a supervision and monitoring plan had been put into place for CNA #6 and that she would no longer be providing care to Resident #6. He said that she had to report to a licensed nurse when reporting to work. She had to let the nurse know what area of the facility she would be working that day, either giving baths or working on the floor. Random observations of the employee would be conducted while providing resident care and she would be continuing and completing training modules and be cleared by the center executive director (CED) and center nurse executive (CNE) before she returned to work. He said he was not able to substantiate the allegation involving CNA #6 and that the investigation was still in progress regarding the allegation involving CNA #1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/30/21 at 1:00 p.m. the NHA provided the completed investigation regarding the verbal abuse allegation involving CNA #1. The allegation was unsubstantiated. Fifty-two residents were interviewed and one of the 52 residents said that she remembered CNA #1 talked loudly and quickly but she never heard her cursing or calling any resident names. IV. Facility failures 1. The facility was aware of the incident of verbal abuse involving Resident #36 and CNA #4. In addition, they were aware of the witnessed verbal abuse reported by Resident #36 involving CNA #1. This placed the resident and all other residents at risk for abuse. 2. The facility failed to investigate and report to the Stage Agency allegations of verbal abuse reported by Resident #36. (Cross-reference F609 failure to report allegations.) 3. The facility was aware of the incident involving Resident #6 and CNA #6 (on 4/25/21) and failed to investigate it until the following day (4/26/21) when it was reported to them during the survey. 4. CNA #6 was allowed to come back to work the following day after allegations of physical abuse toward Resident #6 were reported on 4/26/21. 5. The facility failures placed Residents #36 and #6 and other residents at risk for verbal and physical abuse.

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Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 26246 Based on interviews and record review, the facility failed to report alleged violations of abuse to the State Survey and Certification Agency in accordance with state law involving abuse for two (#36 and #6) of five residents out of 30 sample residents. Specifically, the facility failed to: -Report verbal abuse by certified nurse aide (CNA) #4 directed toward Resident #36 and verbal abuse reported by Resident #36 involving CNA #1 and unknown resident(s); and, -Report physical abuse by CNA #6 towards Resident #6. Findings include: I. Facility policy and procedure The Abuse Prohibition policy, revised April 2021, was provided by the nursing home administrator (NHA) on 4/22/21 at 2:25 p.m. The policy documented in pertinent part, (The facility) prohibits abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter 'patient') property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of the shift worked. -The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law. -The employee alleged to have committed the act of abuse will be immediately removed from duty pending investigation. -All reports of suspected abuse must also be reported to the patient's family and attending physician. -Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. CEDs and Center. -Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies, if required. II. Record review (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident #36 Resident #36 revealed during an interview on 4/21/21 at 10:00 a.m. he had been verbally abused about a month ago by CNA #4. In addition, he said that he had witnessed verbal abuse toward unknown resident(s) about two months ago by CNA #1. He said he had reported the loud yelling by CNA #1 to the director of nursing (DON). Cross-reference F600 for abuse. Record review revealed a nurse note entry documented on 3/7/21 there was a verbal altercation between CNA #4 and Resident #36 in the shower room that was loud enough to be heard outside the room by others (staff). -The facility failed to initiate an investigation into the allegation of abuse (cross-reference F610 for abuse investigations). -There was no documentation these incidents were reported to the State Agency. B. Resident #6 Resident #6 revealed during an interview on 4/26/21 at 10:39 a.m. he had been physically and verbally abused by CNA #6 during a recent bath. Cross-reference F600. Staff were aware of the incident that occurred between Resident #6 and CNA #6 because CNA #6 informed the nurse and other CNAs working that day. -The facility failed to initiate an investigation into the allegation of abuse (cross-reference F610). -Record review revealed there was no documentation regarding the incident between CNA #6 and Resident #6, therefore it was not reported to the State Agency timely. III. Staff interviews The NHA and DON were informed of Resident #36's allegations of abuse during the survey on 4/22/21 at 3:00 p.m. Both the NHA and DON said that they had heard about a verbal altercation between CNA #4 and Resident #36 but did not report it. The DON said the resident had reported to her about hearing loud yelling awhile back, but said she did not pursue it any further. The NHA followed up with the surveyor on 4/22/21 at 4:40 p.m. He asked for more details of what Resident #36 had reported and he said that he had to look into reporting this allegation and CNA #1 and #4 had been suspended. -The facility had reported the allegations to the State Agency, however it was not timely. The NHA and DON were informed of Resident #6's allegations of abuse during the survey on 4/26/21 at 11:14 a.m. The NHA said he would follow up on this right away. The DON said she had heard about the incident with CNA #6, and that it had occurred on 4/25/21 during a bath. The NHA said he was not aware of an incident with CNA #6 and the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/26/21 at 2:20 p.m. the DON said they had reported the allegation of physical abuse to the State Agency and that CNA #6 had been suspended.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 26246 Based on interviews and record review, the facility failed to timely and thoroughly investigate alleged violations of verbal and physical abuse for two (#36 and #6) of five residents out of 30 sample residents. Specifically, the facility failed to: -Timely investigate verbal abuse by certified nurse aide (CNA) #4 directed toward Resident #36 and verbal abuse reported by Resident #36 involving CNA #1 and unknown resident(s); and, -Timely and thoroughly investigate physical abuse by CNA #6 involving Resident #6. Findings include: I. Facility policy and procedure The Abuse Prohibition policy, revised April 2021, was provided by the nursing home administrator (NHA) on 4/22/21 at 2:25 p.m. The policy documented in pertinent part, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the center executive director (CED) or designee will perform the following: -Enter allegation into the Risk Management System (RMS). -Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. -Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two hours after the allegation is made if the event results in serious bodily injury. Serious bodily injury is reportable. Only an investigation can rule out abuse, neglect, or mistreatment. Initiate an investigation within 24 hours of an allegation of abuse that focuses on: -whether abuse or neglect occurred and to what extent; -clinical examination for signs of injuries, if indicated; -causative factors; and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-interventions to prevent further injury. The investigation will be thoroughly documented within RMS. Ensure that documentation of witnessed interviews is included. Conduct interviews, enter a summary of the interviews into RMS. The Center will protect patients from further harm during an investigation. II. Record review A. Resident #36 Resident #36 revealed during an interview on 4/21/21 at 10:00 a.m. he had been verbally abused about a month ago by CNA #4. In addition, he said that he had witnessed verbal abuse toward unknown resident(s) about two months ago by CNA #1. He said he had reported the loud yelling by CNA #1 to the director of nursing (DON). Cross-reference F600 for abuse. Record review documented a verbal altercation between Resident #36 and CNA #4 on 3/7/21. -There was no evidence that an investigation was initiated until 4/22/21 (during the survey), although nursing staff were aware of the incident. -There was no evidence that an investigation was initiated until 4/22/21 (during the survey), although the DON was aware of the report from Resident #36 regarding CNA #1. -There was no evidence the allegations of abuse were reported to the State Agency timely (cross-reference F609 for reporting to State Agency). B. Resident #6 Resident #6 revealed during an interview on 4/26/21 at 10:39 a.m. he had been physically and verbally abused by CNA #6 during a recent bath. Staff were aware of the incident that occurred between Resident #6 and CNA #6 because CNA #6 informed the nurse and other CNAs working that day. Cross-reference F600. -There was no evidence that an investigation was initiated until 4/26/21 (during the survey), although the DON was aware of the incident. Record review revealed there was no documentation regarding the incident between CNA #6 and Resident #6. -There was no evidence of documentation in the resident's record regarding the alleged abuse by CNA #1. -There was no evidence the allegations of abuse were reported to the State Agency timely (cross-reference F609 for reporting to State Agency). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the investigation regarding allegations of verbal and physical abuse towards Resident #6 (reported on 4/26/21 during the survey), was still in the process of being investigated. III.Staff interviews The NHA and DON were informed of Resident #36's allegations of abuse on 4/22/21 at 3:00 p.m. They were both aware of the incident that occurred on 3/7/21, however; they did not initiate an investigation. They initiated an investigation on 4/22/21 and reported the allegation to the State Agency on 4/22/21 (during the survey). The NHA and DON were informed of Resident #6's allegations of abuse during the survey on 4/26/21 at 11:14 a.m. The DON said she had heard about the incident with CNA #6 and that it had occurred on 4/25/21 during a bath, however; she did not initiate an investigation. The NHA said he was not aware of an incident with CNA #6 and the resident. They initiated an investigation on 4/26/21 and reported the allegation to the State Agency on 4/26/21. The NHA and DON said they were not aware of the allegation made by Resident #6 regarding verbal and physical abuse from CNA #1. They said they would initiate an investigation. The facility failed to timely and thoroughly investigate allegations of abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 12905 Based on observations, interviews and record review, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for one (#106) of three residents reviewed out of 30 sample residents. Specifically, the facility failed to ensure Resident #106 received timely assistance with bathing, grooming and dining. Findings include: I. Facility policy and procedure The Activities of Daily Living policy, revised 11/30/20, was provided by the nursing home administrator (NHA) at approximately 6:00 p.m. The purpose was To ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences. Practice standards included: A patient 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 . ADL care is documented every shift by the nursing assistant. The licensed nurse will document ADL care he/she provided, when applicable. II. Resident status Resident #106, age 74, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included Parkinson's disease and unspecified abnormalities of gait and mobility. According to the 4/10/21 admission minimum data set MDS assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. No mood or behavioral symptoms were documented. No rejection of care was documented. He needed extensive assistance with activities of daily living, needed limited physical assistance for eating, and was dependent for bathing. He had range of motion limitations to his upper and lower extremities. He was always incontinent of bowel and bladder. III. Resident interview and observations A. Bathing and grooming The resident was interviewed initially on 4/21/21 at 5:06 p.m. He resided on the 100 hall, which was designated for residents on 14-day observation after admission for COVID-19 precautions. He said he had not received a bath or shower, and had received only bed baths since his admission. His hair was greasy and disheveled and his fingernails were dirty with brown matter underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was interviewed a second time on 4/22/21 at approximately 4:00 p.m. He was lying on his back in bed. The therapy director/occupational therapist stopped by to deliver the resident's new wheelchair cushion. She said he had been on therapy caseload since last week. He had a wheelchair and a new pressure-relieving cushion she had just brought. She was notified the resident was wanting a shower and she said she could get that arranged tomorrow, and get his beard trimmed and hair washed. He looked at his fingernails and said, Oh God, look at my nails! They were still dirty with brown matter underneath. He said he needed washing from stem to stern. He added that he had a pressure sore on his bottom that just opened up, and he was concerned it was not good. He said he had mostly been in bed on his back because he could not get up into his chair. (Cross reference F686 pressure ulcers) The resident was interviewed a third time on 4/26/21 at 8:22 a.m. He said he would get his shower tomorrow; at least he knew when it would happen. -At 3:04 p.m. he was lying in bed on his back watching television. He had food in his beard, his glasses were smeared and needed cleaning, and his hair was greasy and disheveled. His arms and hands were covered with a blanket and were not observed. On 4/27/21 at 8:33 a.m. the resident was lying in bed eating breakfast. The director of nursing (DON) was visiting with him, and they both confirmed he had had a whirlpool tub bath that morning. B. Dining On 4/21/21 at 5:08 p.m. the resident was lying in bed eating dinner from a tray on his overbed table. He had not been repositioned in bed so that he could sit up properly to eat, and was unable to see the bowl of soup at the far right end of his tray. He said he liked the cole slaw and asked for seconds but the staff told him dietary said they had run out. He ate a bowl of canned peaches with his fingers and asked for more so the staff ordered it for him. He reached out to feel the soup bowl at the opposite corner of his tray, pulled out a piece of potato, tasted it and said he did not like the soup. He said he did not need assistance to eat but struggled with his food, dropping almost every bite on his clothing protector before picking it up and putting it into his mouth. On 4/26/21 at 12:19 p.m., a certified nurse aide (CNA) was setting up the resident's lunch tray. He was sleeping, lying almost flat in bed. She raised the head of his bed and positioned his meal tray on his overbed table but did not offer hand hygiene. She removed the lids from his beverage glasses and cups but did not offer any further setup assistance. His head was so far back from the tray and so low that he could not have seen his lunch tray very well. At 12:22 p.m. he had removed the cover from his plate and was eating his lunch (sausage, peppers and onions) with his fingers. On 4/27/21 at 12:05 p.m. the resident was up in his wheelchair at a table in the dining room. He said he was doing well, enjoyed his lunch, and indicated he was glad to be up in his chair although his legs looked and felt a little stiff. He said they were out of the chicken he ordered so he had a grilled cheese sandwich and it was very good. He had not eaten his bowl of soup, and did not have any adaptive utensils at his place setting (see therapy director interview below). IV. Record review A. Nursing notes (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to admission nursing documentation on 4/3/21 at 1:24 p.m., the resident was admitted for Teaching and Training Therapy LTC (long term care), Parkinson's, failure to thrive, neurodegenerative gait disorder. He was alert and oriented x 3 (to person, place and time), very pleasant gentleman, non-ambulatory due to gait issues, is a Hoyer (mechanical lift) 2 person transfer. Pt. (patient) has a history of falls Hypertension Parkinson arthritis . Use friction reducing device to position in bed. B. Care plans The resident's care plan, dated 4/21/21 and revised 4/27/21, documented the following: I would benefit from accommodation for physical limitations by placing items I need or want on my over the bed table. I might need assistance that involve using my hands. I have intermittent pain in my hands and limited ROM (range of motion) in my arms. Requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Adult failure to thrive, Parkinson's disease, age related physical debility. It is important for me to receive a bath. (4/9/21) Diagnosis of Parkinson's disease; at risk for decreased functional mobility, ineffective communication, impaired swallowing. Interventions included: -Assist to turn/reposition every two hours to enable maximal lung expansion -Encourage to chew food thoroughly and swallow normally. Monitor for incidents of aspiration. -Maintain head position and support, with head of bed elevated at least 30 degrees or more immediately after feeding. The resident's care plan for ADLs was not otherwise personalized to his needs. C. ADL records The resident's April 2021 ADL records documented he received bed baths on 4/10, 4/11, 4/13, 4/16 and 4/17/21. He refused bed baths on 4/6, 4/7, 4/8, 4/9, 4/19 and 4/20/21. All other dates during April 2021 were left blank. -For eating, he was documented inconsistently as needing extensive, limited or setup assistance, and as eating independently. -Transfers were documented as N/A (not applicable) or dependent. V. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bath aide, CNA #6, was interviewed on 4/26/21 at 10:38 a.m. She said Resident #106 hasn't had a shower yet - he was supposed to get one today but I'm pulled to the floor due to short staffing. (Cross-reference F725, sufficient nursing staffing.) The therapy director was interviewed on 4/27/21 at 9:07 a.m. She said she was concerned that Resident #106 had just received a bath that morning. She said she did not agree with the policy to provide bed baths only for residents on the 100 hall until they were off isolation, as the residents needed regular showers or baths for hygiene, comfort and dignity. She said Resident #106 tolerated being up in his chair only one meal a day, about one to two hours at a time because it hurt him to sit up for too long because he was so stiff. She said his positioning in bed was difficult with dining; He tends to slide down, partly because he's so stiff. She said her goal for him was to get him up for all three meals, and she asked for him to get into communal dining. I worry about his aspiration risk, and I'm not comfortable with him eating alone in his room. She said he was receiving speech therapy for delays in his motor control, as he was at risk for aspiration. She said the therapy staff noticed a problem with eating and that's why we want him up in the chair so he improves his self-feeding, and is more independent with grooming and hygiene at the sink that way. We are working on building up that tolerance. The NHA and DON were interviewed the evening of 4/27/21. They acknowledged the above concerns and said they were working to address them.

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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** 12905 Based on observation, record review and interviews, the facility failed to ensure highest practicable quality of care regarding skin conditions for one (#24) of two residents reviewed for skin conditions out of 30 sample residents. Specifically, the facility failed to assess, document and timely treat a rash to Resident #24's legs and buttocks and a blister/scab on his toe. Findings include: I. Facility policy and procedures The Skin Integrity Management policy, revised 1/31/2020, provided by the nursing home administrator (NHA) on 4/28/21, included: -The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observe and monitor for changes and implement revisions to the plan of care as needed. -Perform skin inspection on admission and weekly and document in the treatment administration record (TAR) or in Point Click Care (electronic medical record). II. Resident status Resident #24, age 93, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included heart disease, malignant neoplasm of prostate, chronic obstructive pulmonary disease, obstructive and reflux uropathy, and chronic kidney disease. According to the 3/10/21 minimum data set assessment, the resident had severe cognitive impairment with a brief interview for mental status score of eight out of 15. He required extensive assistance with activities of daily living, had an indwelling catheter, and received hospice care since admission. III. Family interview Resident #24's family member was interviewed on 4/22/21 at 9:00 a.m. She said the facility staff had reported to her the other day that he had a blister to his toe from the sheet on his bed, so they tried to fix it so it would not be so tight. She said he had a rash on his back, and she was not sure if that was resolved. IV. Observations The resident was observed during the survey (4/21, 4/22, 4/26 and 4/27/21) always in bed lying on his back, napping frequently, and taking his meals in his room. He was never observed out of bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24's skin condition was observed on 4/27/21 at 11:38 a.m. with licensed practical nurse (LPN) #2 and a hospice aide. LPN #2 explained to the resident that she was going to provide cares and wanted to look at his skin. She pulled the covers down to below his socked feet. The hospice CNA then took off his adult brief. The resident had a red rash that appeared clustered and round from his groin to the tops of both of his thighs, just above both knees. His bilateral inner thighs had solid red excoriation. He had a Foley catheter that was anchored to his left upper thigh. LPN #2 performed catheter care and peri care. After completing peri care, LPN #2 began to apply the medicated cream on the resident's bilateral thighs. The hospice nurse had entered the room and said he had had the rash and it had started on his back. She said it was tinea corporis (a superficial fungal infection) and they were using an anti-fungal cream on it for 10 days. The resident was turned to his right side and the rash was on his bilateral buttocks and back of his thighs. He did not have any open wounds. His anal area was also bright red. LPN #2 said she believed that his inner thighs and anal area were MASD (moisture associated skin dermatitis). She said they were applying barrier cream to these two areas. LPN #2 then removed the resident's socks off both feet. There was a small round black/scabbed area (the size of a pencil eraser) on the tip of his right toe (just below the edge of the nail). She did not measure the area. It did not have a dressing on it. She said that it started out as a blister. She did not think it was pressure-related and the only treatment for it was skin prep and to leave it open to air (however, there were no orders for the skin prep, see below). The hospice nurse said it was reported to her about two weeks ago. V. Record review The resident's skin integrity care plan, initiated on 3/3/21 and revised 4/10/21, identified risk for skin breakdown related to advanced age, decreased activity and poor safety awareness. Interventions included: preventative skin care (lotions, barrier creams as ordered); apply barrier cream with each cleansing; during cares assist with turning and repositioning as needed and upon request; and weekly wound assessments. -The care plan did not document a rash on the resident's body or a blister on his toe. The April 2021 physician orders and medication administration record (MAR) revealed an order dated 4/24/21 for Clotrimazole Cream 1%, apply to legs and buttock topically in the morning for Tinea for 14 days, apply to back of both legs, front of right leg and left buttock. According to the MAR, it was not administered until 4/25/21. -The resident also had an order for Dexamethasone (steroid) tablet 4 mg give one tablet by mouth one time a day for rash, ordered 3/3/21. -There was no physician order for the skin prep as indicated in LPN #2's interview about the right toe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin Check forms on 3/10, 3/17, 3/25, 4/1, 4/8, 4/10, and 4/17/21 revealed no documentation of a toe blister or wound, and no documentation of a rash. A skin tear to the resident's right elbow was documented on 4/10 and 4/17/21, but no other skin issues. -No skin checks were documented after 4/17/21, although the latest one was due on 4/24/21. VI. Staff interview The director of nursing (DON) was interviewed on the afternoon of 4/27/21. She said the resident had the rash when he was admitted to the facility. She acknowledged the lack of documentation regarding the resident's skin and said she would look into it further. -No further information was provided as of 4/30/21.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31797 Based on observations, record review and interviews, the facility failed to prevent pressure ulcers from developing for two (#10 and #106) of three residents reviewed for pressure ulcers out of 30 sample residents. The facility failed to ensure Resident #10 did not develop an unstageable (stage 3 or above-see reference below) pressure ulcer to the trunk area on her back, which was acquired in-house. This resident was chair-fast with Parkinson's disease. The development of the pressure ulcer caused pain to the resident. The facility failed to consistently monitor and provide adequate and timely wound cares, including routine measurements of the wound. No documentation was found for this wound (which was first observed on 2/22/21) from 2/22/21 through 3/27/21. The facility failed to create a care plan related to actual pressure ulcers and treatment. Furthermore, on 4/27/21, nursing staff was observed using a product which was not ordered for Resident #10's wound care. Additionally, the facility failed to ensure Resident #106 did not develop a stage 2 pressure ulcer to his sacrum and right gluteal area, which was acquired in-house. This resident was bed-bound and was not provided with an air mattress. He was not provided with therapy for five days following his admission. There was also a delay in implementing interventions after his wound had been discovered. Findings include: I. Professional reference A. The NPUAP Pressure Injury Stages | The National Pressure Ulcer Advisory Panel - NPUAP. The National Pressure Ulcer Advisory Panel NPUAP. Web. (undated) http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages reads: A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence as a result of pressure, or pressure in combination with shear. The updated staging system includes the following definitions: -Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema. -Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. -Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. -Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar was removed, a Stage 3 or Stage 4 pressure injury will be revealed. B. According to the National Pressure Ulcer Advisory Panel (NPUAP), Pressure injury prevention points, updated 2016, revealed in part Consider bedfast and chairfast individuals to be at risk for development of pressure injury; Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within eight hours after admission); Use heel offloading devices .on individuals at high risk for heel ulcers. I. Facility policy and procedures The Skin Integrity Management policy, revised 1/31/2020, was provided by the nursing home administrator (NHA) on 4/27/21 at 6:00 p.m. It documented the purpose of the policy was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment and promote healing of all wounds. It documented staff should continually observe and monitor residents for changes and implement revisions to the plan of care as needed. It documented staff should perform skin inspections on a weekly basis, perform wound observations and measurements and complete the Skin Integrity Report upon initial identification of altered skin integrity weekly and with anticipated decline of wound and perform daily monitoring of wounds or dressings for presence of complications or declines and document. The policy documented the facility should develop comprehensive, interdisciplinary plans of care, including prevention and wound treatments, as indicated. They should implement skin/wound care guidelines as applicable, review co-morbid conditions that may affect healing, notify dietician and/or rehabilitation services as indicated, notify the physician to obtain orders, review the care plan weekly and revise as indicated and document daily monitoring of ulcer site (with or without dressing). The policy documented for wounds that do not require a daily dressing change, monitor status of the dressing (intact and clean), status of tissue surrounding the dressing (free of new redness or swelling) and adequate control of wound pain. II. Resident #10 A. Resident status Resident #10, age 91, was admitted on [DATE]. According to the face sheet, diagnoses included Parkinson's disease, vascular dementia, diabetes mellitus with diabetic polyneuropathy, spondylosis in the lumbar region, abnormal posture and other reduced mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 3/5/21 minimum data set (MDS) assessment documented the resident was cognitively intact for daily decision making with a brief interview for mental status score of 15 out of 15. She required extensive assistance of one for bed mobility and dressing. She required extensive assistance of two for transfers and toileting. She was independent with ambulation once assisted into her wheelchair. She did not reject care. Section M, skin condition, of this MDS documented the resident had a pressure ulcer/injury, a scar over bony prominence. It documented Resident #10 was at risk for developing pressure injuries and that she had one or more unhealed pressure injuries. It documented the resident had one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar. B. Observations of Resident #10 and interview Resident #10 was initially interviewed on 4/21/21 at 10:28 a.m. She said she had a sore on her back that she acquired in the facility when she had COVID-19, was very ill and essentially bed-bound and was isolated in her room. She said facility staff did not look at her back very often and that she had some pain in the area of that sore. She said they put some type of a bandage over the wound and she did not know what the wound looked like because she could not see her back. The resident had an air cushion on the seat on her wheelchair, but did not have a cushion for the back on the chair. On 4/22/21 at 8:08 a.m. Resident #10 was sitting in her wheelchair in her room. She was crocheting a red afghan and appeared happy and content with this task. -At 10:25 a.m., the resident was in the same position and continued to be content with her crocheting. - At 1:33 p.m. Resident #10 was in her room, seated in her wheelchair, crocheting her afghan. She said she was still at it because she wanted to make up for lost time when she was quite ill with COVID-19. -At 3:45 p.m., the resident was still in her wheelchair working on her afghan. On 4/26/21 at 8:30 a.m. Resident #10 was seated in her wheelchair in the dining room. She was working on a word puzzle book. -At 11:50 a.m., she was in the dining room doing her word puzzle search and enjoying stuffed peppers that her daughter made for her. -At 1:05 p.m., Resident #10 was in her room, up in her wheelchair working on her afghan. -At 3:45 p.m., the resident was seated in her wheelchair, watching television and crocheting. On 4/27/21 at 8:00 a.m. Resident #10 was eating breakfast in the dining room after working on her word search puzzles earlier that morning. -At 8:30 a.m., the resident remained in the dining room visiting with a staff member. -At 11:50 a.m., the resident was in the dining room, eating the meal her daughter prepared as well as a Wendy's frosty. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	C. Interview with director of nursing (DON) The DON was interviewed on 4/26/21 at 9:01 a.m. She said the facility did not have a wound nurse, but they were trying to hire one. She said she and the nurse managers had been doing the wound care in the facility. She said the facility had an action plan because of communication problems in the facility with identifying new pressure injuries in a timely manner. She said the floor nurse was providing wound care for Resident #10 and she would check with the nurse to see when her wound could be observed the following day. D. Observations of wound care to right trunk Licensed practical nurse (LPN) #3 was interviewed on 4/27/21 at 10:00 a.m., while making wound care observations for Resident #10. The LPN practiced hand hygiene with soap and water prior to beginning the wound care. LPN #3 placed a clean pad on the resident's bed for a clean surface in which to work from. She cleaned a pair of scissors with alcohol. The resident had not been pre-medicated for pain prior to wound care. Resident #10 said she currently had no pain in the wound area unless she directly laid on the wound. She said she did have quite a bit of pain in the wound area when the injury first occurred. LPN #3 cleansed the wound with SkinTegrity, working in circles from the inside of the wound to the outer areas. She said the pressure injury was an unstageable wound because you could not see the wound bed due to the eschar. She said no exudate (drainage) was observed. She used Maxorb AG with silver for the inner dressing. She did not measure the wound. She did not provide measurements of the wound until specifically asked. She described the wound as 1 centimeter (cm) x 1 cm. She did not give a depth measurement of the wound. She said she did not routinely measure pressure injuries unless specifically requested by the director of nursing (DON). This dressing was covered with an outer Optifoam dressing and dated. She said the wound initially looked like an abrasion, but was located over a bony prominence, so was changed to a stage 2 pressure injury. She said she did not think there was any undermining, but she could not see under the wound bed. She said the scab was directly over the wound. She said she felt the wound was looking good and healing nicely. She said the dressing was changed on the resident's bath days and as needed. She said the dressing usually stayed in place until the resident's next bath day. The LPN said the wound was acquired in-house, but could not remember specifically how long ago. She said the wound started when the resident had COVID-19. She said the resident had lost a lot of weight during COVID-19 and she developed the pressure injury over a bony prominence over her back area of right trunk. She said the resident had been eating more recently and her skin integrity had improved. She said there was no sign of infection or moisture associated with the wound. E. Record review 1. Skin assessments There were no other skin assessments seen in the resident's electronic chart from 2/22/21 until 3/27/21 (see below). No other skin assessments were provided by the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Braden scale for predicting pressure sore risk assessment dated [DATE] did not include a score. It documented the resident's sensory perception was slightly limited and she was occasionally moist. It documented she was chair-fast and her mobility was very limited. It documented her nutrition was very poor. It documented she had a potential problem for friction and shear. The skin check assessment dated [DATE] documented no skin injury was identified. The skin-tear/abrasion/laceration assessment dated [DATE] documented a trunk abrasion measuring 1 cm x 1 cm (centimeter). The skin check assessment dated [DATE] documented no skin injury was identified. The skin-tear/abrasion/laceration assessment dated [DATE] documented the truck wound was first observed on 2/22/21. The wound measured 1 cm x 1 cm. The skin-tear/abrasion/laceration assessment dated [DATE] documented the trunk wound was first observed on 4/22/21 (which was after the date of this assessment) and it was acquired in-house. It measured 0.75 cm long and 0.75 cm wide. It was being left open to air. It documented weight loss was a contributing factor leading to decline. It documented the wound had not changed. The skin check dated 4/17/21 documented moisture associated skin damage, as her groin/peri area was inflamed. -This check did not mention the resident's unstageable pressure injury to her right trunk area. The Skin-Pressure Ulcer assessment dated [DATE] documented the resident had an unstageable pressure injury on her right posterior trunk, which was first observed on 2/22/21. It was acquired in-house. It documented the deepest stage had been stage 2 with no drainage. The wound appearance included 1-24% epithelial tissue. The surrounding tissue was described as healthy. The wound edges were distinct. The wound measured 0.75 cm x 0.75 cm with no depth documented. It documented the facility was using a foam dressing as the secondary dressing. It documented the resident was receiving nutritional treatment and the care plan was updated. It documented the resident was on a turning program, but did not specify how often she should be repositioned. The skin check assessment dated [DATE] documented the resident had skin injury/wounds identified. It documented the resident was at risk for skin breakdown related to decreased mobility, incontinence age and diabetes. It documented the resident had an actual pressure ulcer to her truck, stage 2, on the right side. The injury status was changed from an abrasion to a pressure ulcer on 4/16/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interventions included encouraged the resident to consume all fluids of her choice during meals, observe skin for signs/symptoms of skin breakdown, evaluate for any localized skin problems, observe skin condition daily with ADL care and report abnormalities, off load/float heels while in bed, utilize (un-named) device to assist resident with turn/positioning to reduce friction/shear, lower extremity protectors, upper extremity protectors, observe for verbal and non-verbal signs of pain related to wound or wound treatment and medication as ordered, obtain dietician consult as needed/ordered, pat (do not rub) skin when drying, obtain skilled PT (physical therapy)/OT (occupational therapy) evaluation to improve functional mobility, pressure redistribution surface to bed as per guideline, pressure redistribution surfaces to chair as per guideline, provide wound treatment as ordered, provide supplements as ordered, weekly skin evaluation by licensed nurse, provide patient and/or healthcare decision maker education regarding risk factors and interventions, provide preventative skin care (i.e. lotions, barrier creams as ordered) and apply barrier cream with each cleansing. 2. Care plan Resident #10's care plans of 3/5/21 were reviewed. There was no care plan related to actual pressure injuries. -There were no care plans related to pressure injuries created after the wound was first identified on 3/29/21. The care plan related to skin breakdown, dated 3/5/21, was reviewed and documented Resident #10 was at risk for skin breakdown due to decreased mobility, incontinence, age and diabetes. Interventions included providing preventative skin care (i.e. lotions and barrier creams) as ordered, observe skin for signs/symptoms of skin breakdown daily with ADL care and report abnormalities, utilize (left blank) device to assist resident with turning/positioning to reduce friction/shear, obtain dietician consult as needed, pressure redistribution surfaces to bed and chair as per guideline, provide wound treatment as ordered and weekly skin assessment by licensed nurse. 3. Computerized physician orders (CPO) The April 2021 CPO was reviewed. It documented the following was ordered on 4/16/21, but not started until 4/20/21: Wound right flank. 1. Clean with wound cleanser; 2. Apply Optifoam AG; 3. Change on bath days and prn (as needed). QD (every day) every Tuesday and Friday for wound care. There was no order seen for the use of Maxorb AG with silver for the use with Resident #10's pressure injury as seen during the observation LPN #3 used. There was no order seen in Resident #10's electronic chart related to leaving the wound open to air, as mentioned in the DON's interview of 4/27/21 (see below). 4. Medication administration record (MAR) The April 2021 MAR documented the above wound care was performed on 4/20/21, 4/23/21 and 4/27/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- However, during the 4/27/21 wound care observation at 10:00 a.m. (see above), LPN #3 used Maxorb AG with silver for the dressing, along with Optifoam AG as the outer dressing. F. Additional staff interviews The DON was interviewed again on 4/27/21 at 10:53 a.m. She said Resident #10's wound developed because the resident used to have her bed against the wall and always laid in bed on her right side. She said the wound started developing, grew a bit more and then erupted. She said the facility spoke to the resident about her positioning in bed and the resident agreed to move the bed so she could turn on her other side. The DON said eschar then appeared and the facility's medical director observed the wound with the DON. The DON said they were leaving the wound open to air to let it self-debride. She said the resident was a slow healer due to co-morbid issues. She said the facility did not begin using dressings until 4/16/21 and was prompted when the resident told the DON the area hurt her. The DON said the evening of 4/15/21, someone put a foam dressing on the wound. The eschar had gotten soft and had been pulled off, as it adhered to the dressing. She said the wound had been classified as unstageable because it had eschar and she was now classifying the wound as an unhealing unstageable because you cannot back stage pressure injuries. The DON said that the resident's bed positioning should have been identified and addressed, especially when the resident was quite ill with COVID-19. She said facility staff probably should have encouraged the resident to reposition more often in order to prevent the pressure injury from occurring in-house in the first place. She said, in order to promote wound healing and minimize further wounds, as the resident was still thin following her illness, facility staff should be observing skin condition with all care, repositioning the resident with all care, observing the resident for continued pain, obtaining a dietary consultation and involving therapy as needed. She said the resident had recently a pressure redistribution mattress and chair cushion. She said she would now be requiring weekly evaluations of skin on the resident's entire body in order to detect skin issues in a timely manner. She said the facility would be providing supplements for wound healing, along with high protein snacks. She said the resident's daughter had been bringing food to her mother to try to get her to eat more and gain some weight back. She said a might shake had been ordered prior, but had been discontinued. She was uncertain as to what dates these were. The NHA was interviewed on 4/27/21 at 5:53 p.m. He said the facility had an action plan developed for skin and they conducted an ad hoc QAPI meeting the day prior, after becoming fully aware of the in-house acquired pressure ulcer that Resident #10 sustained. He said he understood it was an issue due to lack of wound measurements for the pressure injuries. He said the facility was aggressively in the process of hiring a wound nurse. He said the assistant director of nursing (ADON) who normally helped with wound care had been out on leave for a family emergency. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	He said the facility would be willing to pay for a nurse to become wound certified. He said the action plan had identified some issues such as reviewing skin assessments on a daily basis for completeness and accuracy, ensuring proper mattresses and cushions were in place, providing further education with floor nurses on communication issues related to skin care and knowledge into the appropriate use of cushions and surfaces before skin injuries become an issue. He said it was his expectation for the certified nurse aides and bath aides to report skin issues immediately to nurses and for skin assessment audits to be performed at least weekly. 12905 III. Resident #106 A. Resident status Resident #106, age 74, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included Parkinson's disease and unspecified abnormalities of gait and mobility. According to the 4/10/21 admission MDS, the resident had severe cognitive impairment with a BIMS score of seven out of 15. No mood or behavioral symptoms were documented. He needed extensive assistance with activities of daily living, was dependent for bathing, and used a wheelchair for mobility although ambulation did not occur during the review period. He had range of motion limitations to his upper and lower extremities. He was always incontinent of bowel and bladder. He had no pressure ulcers and had a pressure reduction mattress and wheelchair pad. -The pressure reduction mattress was not an alternating air mattress, see last observation and the director of nursing interview below. The resident was unable to offload his weight on his own. B. Resident interview and observations The resident was interviewed initially on 4/21/21 at 5:06 p.m. He resided on the 100 hall, which was designated for residents on 14-day observation after admission for COVID-19 precautions. He said he had not received a bath or shower, and had not received therapy services. He was lying on his back in bed. (Cross-reference F677 activities of daily living) The resident was interviewed a second time on 4/22/21 at 4:32 p.m. He had been moved to the 300 hall. He said he had a pressure sore on his bottom that had just opened up. He said it was difficult for him to move his body from side to side. Observations of the resident throughout the survey-on 4/21, 4/22, 4/26 and 4/27/21 from approximately 8:30 a.m. to 6:00 p.m. - revealed he was bedbound and was always lying on his back. He had range of motion limitations to his hands and arms. On 4/27/21 at 2:40 p.m. Resident #106's wound was observed with registered nurse (RN) #1. Upon entering the room the resident was lying on his back in bed covered with his sheets. The nurse explained to the resident that she needed to look at his skin. She then uncovered him and with the help of a CNA, helped him turn to his left side and removed his adult brief. There was a large Mepilex dressing covering his entire buttock area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-There was a small open area on his lower right buttock. The RN said it was dime sized and a stage 2 because the skin was broken. There was no depth to the wound; there was no drainage. The surrounding tissue was healthy, pink and blanchable. -RN #1 said his wound was acquired here from the previous mattress that he was on. She said there currently was no treatment order for the wound other than the Mepilex dressing. She said due to his Parkinson's he could not tolerate position changes and that now that he has the air mattress it will provide rotating air pressure. (The air mattress had just arrived on the afternoon of 4/27/21-see DON interview below.) C. Record review According to the 4/3/21 nursing assessment, the resident had no skin issues, was at risk for developing pressure sores, and was unable to move side to side in bed. Review of Braden Scales for Predicting Pressure Sore Risk assessments revealed the first assessment was dated 4/10/21, seven days after the resident's admission. He scored 16, mild risk, with no sensory perception impairments, skin was often moist, he was chairfast, his mobility was very limited, nutrition was adequate, and friction/shear was not an apparent problem. -On 4/17/21, he scored 10 high risk, with completely limited sensory perception, skin often moist, bedfast, mobility very limited, nutrition adequate, and friction/shear were a problem. -On 4/22/21, he scored 10 high risk, with sensory perception slightly limited, skin constantly moist, chairfast, completely immobile, nutrition probably inadequate, and friction/shear were a problem. According to the resident's skin assessments dated 4/10/21 and 4/17/21, he had no pressure injuries upon admission. According to nursing notes, a stage 2 pressure sore was first discovered on the resident's buttock on 4/22/21 at 3:26 p.m. He had no air mattress yet, but nursing staff had requested one. On 4/26/21 the DON provided a Skin Integrity Report form where she had documented the resident's pressure sore on 4/22 and 4/26/21 as a stage 2, no pain, with epithelial tissue, 1 cm x 1 cm with no depth, no undermining, no drainage, inflamed surrounding tissue, healthy wound edges, no odor, care plan updated on 4/26/21. Review of physician orders revealed the resident had no wound care orders until 4/25/21, although the wound was identified on 4/22/21: -hydrocolloid dressing to sacrum and right gluteal area. DX (diagnosis) stage 2 pressure ulcer as needed for pressure ulcer sacrum change dressing as needed and -hydrocolloid dressing to sacrum and right gluteal area. DX stage 2 pressure ulcer every 72 hours for stage 2 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	His skin integrity care plan, initiated 4/6/21 and revised 4/10/21 and 4/26/21, was not revised regarding the pressure sore until 4/26/21, four days after the pressure sore was discovered, and no interventions to promote healing were added other than physician orders. The care plan focus documented he was at risk for skin breakdown related to Parkinson's with decreased activity, incontinent of both bowel and bladder and hydrocolloid dressing to sacrum and right gluteal area. DX stage 2 pressure ulcer (4-22-21). The goal was no skin breakdown for 90 days. Interventions were: -Bed bath 2 times weekly (4/21/21) -Pat (do not rub) skin when drying (4/6/21) -Provide preventative skin care i.e. lotions, barrier creams as ordered (4/6/21) -Apply barrier cream with each cleansing (4/6/21) -During cares assist with turning and repositioning as needed and upon request (4/10/21) -Observe skin for signs/symptoms of skin breakdown (4/6/21) -Observe skin conditions daily with ADL care and report abnormalities (4/6/21) -Obtain dietitian consult as needed/ordered (4/6/21) -Obtain skilled physical/occupational therapy evaluation to improve functional mobility (4/6/21) -Weekly skin check by licensed nurse (4/6/21) Review of the April 2021 treatment administration record (TAR) revealed the resident's wound dressing was not applied until 4/25/21 at 7:52 p.m., three days after the pressure sore was first observed. D. Staff interviews The director of nursing was interviewed on 4/26/21 at 8:30 a.m. and 9:00 a.m. She said she had ordered an air mattress for the resident, but had to order it from a company in Denver and had no estimated time of arrival. She said they had an action plan in place regarding communication, documentation, skin assessments, wound assessments and follow-through regarding pressure injuries. They have no wound nurse, were trying to hire one, and she and the nurse managers were doing wounds now. She said she was going to get an air mattress on the resident's bed. The nurse on duty yesterday was in and out of his room a lot, turning and repositioning him. She acknowledged the resident's wound was first discovered Thursday afternoon (4/22/21) and the nurse documented as if it was new yesterday (4/25/21). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to prevent Resident #106's inhouse-acquired stage 2 pressure sore from developing by not implementing the appropriate interventions for Resident #106, who required extensive assistance from staff with ADLs and had limited range of motion to his upper and lower extremities. Furthermore, the facility failed to implement timely interventions to promote healing and prevent further skin breakdown.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12905 Based on observations, interviews and record review, the facility failed to ensure three (#106, #14 and #20) of 12 residents reviewed out of 30 sample residents received adequate nutrition/hydration interventions to prevent weight loss and ensure adequate nutritional parameters were met. Resident #106, who was admitted [DATE] with adult failure to thrive and advanced Parkinson's disease, experienced severe 14.43% weight loss in one month of admission. The facility failed to assess and respond to his nutrition/hydration risk, failed to identify and provide for his dining assistance needs and food preferences and consistently weighed the resident as indicated in the physician's orders. Dietary and nursing staff were unaware, and failed to identify and communicate the resident's weight results which showed severe avoidable weight loss. Additionally, to facility failed to: -Resident #14, who received hemodialysis, did not have his nutritional needs consistently met, did not have weights obtained consistently to monitor his nutritional status and did not receive the appropriate assistance and oversight for dining; and, -Resident #20 continued to lose weight, her weights were not consistently obtained according to the physician's order and her dietary preferences were not honored. Findings include: I. Facility policy and procedure The Diet and Nutrition Care Manual, dated 2019 (no month), was provided by the director of nursing (DON) on 4/27/21 at 11:17 a.m. The policy documented in part, The dietary guidelines are a critical tool used by professionals to help Americans make healthy choices in their daily lives with a goal of preventing chronic disease and enjoying a healthy diet . Considerations in menu planning for post-acute and long care settings: Many professionals are concerned that the volume of foods needed to meet the guidelines would be almost impossible for most individuals living in post-acute and long term care settings to consume. Other considerations include customer satisfaction: -Contribute to quality of life, considering food preferences and personal choice; -Provide therapeutic diets and consistency alterations with the most individualized and least restrictive diet possible, as appropriate to encourage intake; -Provide eye-appealing and tasty meals to encourage food intake; -Meet Recommended Dietary Allowances (RDAs) are defined as nutrient intake level that meets the requirement for nearly all people in a specific age group and gender. Adequate intake (AI) is the level of nutrient intake of healthy people assumed to be adequate; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Meet the needs of individuals who sometimes feel the volume of food is overwhelming; -Provide sufficient nutrients for individuals with acute and chronic illnesses who often cannot eat enough food to provide sufficient calories and other nutrients-and therefore; are at risk for unintended weight loss, malnutrition, dehydration and other complications; and, -Meet all state and federal regulations. II. Resident #106 A. Resident status Resident #106, age 74, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included Parkinson's disease and unspecified abnormalities of gait and mobility. According to the 4/10/21 admission minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. No mood or behavioral symptoms were documented. He needed extensive assistance with activities of daily living, needed limited physical assistance for eating, and was dependent for bathing. He had range of motion limitations to his upper and lower extremities. He was always incontinent of bowel and bladder. He had no swallowing disorders, was 66 inches tall and weighed 185 pounds. B. Observations and resident interviews Observations and interviews during the survey (conducted 4/21, 4/22, 4/26 and 4/27/21) revealed the resident had difficulty with eating due to range of motion limitations and lack of assistance, was at risk for aspiration, and his food choices and requests were not consistently honored. The resident was observed to request a second helping and an alternate meal for two separate meals, and neither of the requests were honored because the facility was out of the requested item or it was not on the menu. (Cross-reference F677-activities of daily living for dependent residents, and F561-choices.) C. Record review The April 2021 physician orders documented a regular liberalized diet. Physician orders further documented Weigh every day shift every Sat for 4 weeks, ordered 4/5/21, start date 4/10/21, end date 5/8/21. The resident had a new order for Protein Liquid give 30 ml by mouth two times a day for wound management, initiated on 4/26/21 (during survey and four days after a Stage 2 pressure ulcer was identified-cross-reference F686 pressure ulcers). The resident's documented weights since admission, via mechanical lift, revealed he had a severe 14.43% weight loss within less than a month: 4/3/21-185 lbs.; 4/17/21-140.9 lbs.; and, 4/24/21-158.3 lbs. which resulted in a 14.43% weight loss from the initial weight on 4/3/21. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-No weekly weight was documented on 4/10/21. There was no evidence of a reweigh, or communication to the interdisciplinary team, physician or dietary/registered dietitian after the above severe weight loss was documented under the vital signs section of the resident's chart (see nutritional assessment and progress notes below). The 4/7/21 nutritional assessment documented the resident's weight was 185, usual body weight (UBW) was 180 and body mass index (BMI) was 29.9. The goal was to maintain weight, and there were no nutritional problems. The resident was independent with eating and able to make needs known. He was on a regular liberalized diet. No labs were available. Reassessment per protocol was needed. Review of the resident's undated preferences list revealed he disliked eggs, and no likes were documented. Review of interdisciplinary team (IDT) notes revealed no evidence of an IDT discussion about the resident's weight loss. A nutrition progress note dated 4/7/21 by the registered dietitian (RD) documented his nutritional assessment was completed and no concerns were identified. No nutritional diagnoses were identified (although, see above resident status, the resident had a diagnosis of adult failure to thrive). Nursing notes revealed a stage 2 pressure ulcer was identified on 4/22/21 but there was no documentation of RD or physician notification on 4/22/21. (Cross-reference F686 failure to prevent pressure ulcers and promote healing.) The nutrition care plan, initiated 4/8/21 and revised 4/26/21, identified nutritional risk related to Parkinson's and adult failure to thrive. On regular textures, eats independently and weight stable. The goal was to maintain a stabilized weight of plus or minus five percent on current body weight through the 4/30/21 target date. Interventions, all dated 4/8/21, included: -Honor food preferences within meal plan; -Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake; -Provide diet as ordered; -Offer snacks; -Offer alternate food choices of less than 50% consumed at mealtime; and, -Control any pain or nausea before meals. Review of the resident's meal intake records from admission on 4/3/21 through 4/27/21 revealed the following meal intake was documented: Breakfasts: eight blanks or zeros, 10% once, 25% 11 times, 50% twice, 75% twice; Lunches: two blanks or zeros, 20% three times, 25% five times, 50% eight times, 75% twice, 100% three times; and, Dinners: 17 blanks, refused once, 80% five times, 100% once. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-There was no documentation that alternate food choices were offered when the resident ate less than 50%. No snack intake records were provided. D. Staff interviews The dietary manager (DM) was interviewed on 4/27/21 at 10:30 a.m. She was notified of the resident's request for seconds of cole slaw at a lunch meal, potatoes and bacon at a breakfast meal, that neither request was honored because those items were unavailable, and of the weights documented (above). The DM said, That's a significant weight loss either way. (The RD) asks for reweighs and sometimes they don't get done. He should be able to get bacon. I'll keep bacon in stock. I was told by the corporation that we follow the menu. We used to serve bacon, sausage, eggs, everything, but now I can't get it in the budget. She said the NHA told her yesterday if residents haven't had significant weight loss and it's not on the menu not to provide it due to budget. If we provide for one then everyone else will want it too. She said now that she knew Resident #106's weights, which I should have looked up yesterday, if he wants bacon and potatoes, I'll write that down. I'm preferencing him for lunch and dinner. Now that I see these weights I think he should be in the dining room. I'm going to suggest to (the DON and NHA) that (Resident #106) comes down here and eats. Regarding seconds being unavailable when Resident #106 requested, the DM said they always made an additional five to 10 servings, so seconds were available and they kept the food on the line 15 to 20 minutes after each meal to make sure. She said, Mostly that's about CNAs not wanting to come and get extras for residents. The NHA was interviewed on 4/27/21 at 4:48 p.m. He said the facility used to serve huge breakfasts every day with choices of eggs to order, sausage, bacon, potatoes, and sometimes pancakes or waffles in addition and it was beautiful, but their food budget had been reduced and they were unable to continue with those menu items. He said he had spoken with the dietary manager and Resident #106 will be getting potatoes and bacon for breakfast. We are going to do everything we can, and encourage him to come into the dining room. The RD should be working with him on this. The RD was interviewed by phone on 4/29/21 at 10:00 a.m., as she was out of state on vacation. She said she had completed Resident #106's nutritional assessment before his weights reflected weight loss, and she did not recall being notified of his weight loss or pressure ulcer. She said there were so many weight discrepancies at the facility it was overwhelming. She said she had a nutrition-at-risk meeting every Monday with the DON where they discussed residents who had experienced weight loss. She said the DM was pretty good at documenting residents' preferences. When residents asked for foods that were unavailable or not on the menu, she said, I don't like responding with a 'no.' I'll offer something similar, and if they're adamant I'll go to the NHA and ask. Sometimes (the DM) will even purchase items on her own. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	She said that due to budget restrictions, An a la carte kitchen - we can't do that. But the response to residents is very important. We can find ways to brainstorm together. Food preferences should matter. The RD said that on her visits to the facility, she reviewed ADL (activities of daily living) books and reviewed food and fluid intakes, talked with the DM and NHA and observed residents during meals to see if they were getting help at meal times, and looked at adding fortifying meals if needed. She said she would need to reassess Resident #106. -No additional documentation was provided by the facility regarding Resident #106's weight loss before exit on 4/27/21. 31797 III. Resident #14 A. Resident status Resident #14, age 60, was admitted on [DATE]. According to the undated face sheet, diagnoses included dependence on renal dialysis, peptic ulcer and gastrointestinal hemorrhage. According to the minimum data set (MDS) assessment dated [DATE], the resident had moderate cognitive impairment for daily decision making with a brief interview for mental status (BIMS) assessment of eight out of 15. It documented the resident was independent with set-up for eating. It documented he displayed no symptoms of a possible swallowing disorder. It documented the resident was 5'9 and weighed 173 pounds. Nutritional approaches included a therapeutic (renal) diet. It documented the resident was receiving dialysis. B. Resident observations and interviews Resident #14 was initially observed on 4/21/21 at 10:49 a.m. He was sound asleep in his darkened room, turned to the wall. His breakfast tray, which remained untouched, was observed on his bedside table. -At 12:28 a.m., the resident remained asleep and at this time, his lunch tray was observed untouched, on the bedside table. -At 2:52 p.m., the resident was awake, but somewhat resistant to being interviewed. He said he was living in a facility which was not his hometown because he needed dialysis. He said he was hungry and wanted his lunch tray warmed up. The facility did not warm up his meal because it had been left out too long. Resident #14 was observed on 4/22/21 at 8:40 a.m. He was getting ready to go to his dialysis appointment. Licensed practical nurse (LPN) #1 said the resident received dialysis on Tuesday, Thursday and Saturdays mornings from approximately 8:50 a.m. through sometime after lunch. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-At 1:33 p.m., the resident was still at the dialysis clinic. An unidentified certified nurse aide (CNA) stated he was expected back at approximately 2:30 p.m. There was no meal tray delivered for this lunch, as the facility was aware the resident was at dialysis. -At 3:29 p.m., the resident had returned from dialysis. He was lying in bed and said he had no issues or concerns at this time. He stated his weight fluctuated quite a bit, partially due to dialysis and partially due to the food served in the facility. He said it was cold quite a bit, but could give no further specifics about food palatability. Resident #14 was observed on 4/26/21 at 8:25 a.m. He was in bed in his darkened room with his eyes closed. -At 11:50 a.m., the resident remained asleep in bed; he had not received his room tray yet. -At 12:13 p.m., the resident's room tray had been delivered. It was on the resident's bedside table, uncovered. The resident remained asleep in bed. -At 1:00 p.m., the resident remained asleep and his uncovered room tray was untouched. -At 3:17 p.m., Resident #14 was now awake and had eaten a small portion (approximately 25%) of his cold room tray. He said the food did not taste good and requested a grilled cheese sandwich and a cookie to tide him over until dinner. Resident #14 was interviewed on 4/26/21 at 3:30 p.m. He said he did eat some of his room tray when he woke up, but only ate about one third of it, as it was cold and unappetizing. He said he asked someone to warm up his tray, but they would not, saying it had been left out too long to be warmed. He said they offered him a cold sandwich earlier, but that did not sound good to him and that was why he asked for a grilled cheese sandwich and a cookie to tide him over until dinner. He said he appreciated someone asking him if he would like anything else. He said he was rarely asked about that. Resident #14 was observed on 4/27/21 at 8:20 a.m. He was in bed, but awake and in his darkened room wearing sunglasses. He said he had them on because he was getting ready to go to dialysis. His covered breakfast tray remained untouched. He said he did not want to talk at this point in time because he was tired. C. Record review 1. Care plan There was no care plan in the resident's chart related to nutrition, despite the fact the resident was receiving dialysis three times per week. 2. Resident weights 10/1/2020: 173.0 11/1/2020: 167.8 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	12/22/2020: 165.8 (Post dialysis) No weight documented for January 2021 2/4/21: 144.2 (Post dialysis) 3/4/21: 147.4 4/10/21: 181.6 (Post dialysis), 34.2 lbs weight gain from previous weight. -There were no nutrition progress notes/assessments addressing the resident's significant weight changes until 4/22/21, which was identified during the survey. 3. Nutritional assessment The nutritional assessment completed by the registered dietitian (RD) and dated 2/17/21 documented the resident was 5'9 and his BMI (body mass index) was 25.6. He received a liberalized renal diet. It documented CURRENT -resident continues to dine independently and reports a good appetite. Will request peanut butter and jelly sandwiches prior to dialysis and is aware that peanut butter is outside of renal diet recommendations. PREVIOUS - resident dines independently in his room, able to feed self and make needs and wants known. It documented most meal intakes were recorded as 75% or greater. It documented Resident #14 received a Zone protein bar three times per week while at hemodialysis. This assessment documented the resident received a renal diet related to end-stage renal disease and type II diabetes mellitus (which was not on the resident's face sheet). It documented the resident's current weight was stable (+five pounds or 2.8% over target weight for dialysis). It documented no new nutrition problems or diagnosis at this time and to continue with the current nutrition plan of care. -However, the resident did not have a care plan related to nutrition (see above). In addition, the resident's meal intakes were documented as 75% or greater, however based on observations (see above) his meal intake was less. The RD note, dated 4/22/21 (written during survey), documented Resident #14 was triggering for significant weight gain of 23.2% in 30 days. It documented the weight recorded in the resident's electronic record for 4/10/21 was actually pre-dialysis weight instead of the previously documented post-dialysis weight. It documented the RD visited with the resident and he felt he had been losing weight. He stated he had not received his house supplement for several weeks. It documented the resident continued to request food outside of his renal diet despite renal diet education. -However, the RD note did not address the resident's poor intake (see below). 4. Meal intakes The March 2021 meal intake records documented Resident #14 refused meals four times this month, mostly for breakfast. It documented the facility failed to document Resident #14's meal intakes on nine occasions, mostly occurring at lunch. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The April 2021 meal intake records documented Resident #14 refused breakfast twice and his lunch once. It documented the facility failed to document the resident's meal intakes five times for the supper meal. The April 2021 meal intake records revealed the following meal intakes correlating to the above observation dates: 4/21/21 breakfast: 25% 4/21/21 lunch: 75% 4/22/21 breakfast: 100% 4/22/21 lunch: no lunch documented, as resident out of the facility 4/26/21 lunch: 100% was documented, but was not consistent with observation of resident consuming approximately 33% (see above) 4/27/21 breakfast: resident refusal documented D. Staff interviews The dietary manager (DM) was interviewed on 4/21/21 at 2:59 p.m. She said the kitchen could offer the resident a sandwich of his choosing to tide him over until dinner. She said having food left out for approximately three hours after the lunch tray had been dropped off was not acceptable and she was not comfortable in just warming up his lunch tray for him. The director of nursing (DON) was interviewed on 4/26/21 at 3:30 p.m. The DON said she was working on getting only dry weights for this resident due to the significant weight fluctuations in his chart, as the facility staff had been taking both post dialysis weights and pre dialysis weights interchangeably. She said it was impossible to monitor the resident's true weights and address nutritional issues and parameters without accurate weights being taken into consideration. The dietary aide (DA) was interviewed on 4/26/21 at 3:35 p.m. He said normally CNAs drop the meal trays off in the resident's room and they were expected to let the dietary department know if the resident was sleeping. He said the CNA should have left the tray covered when delivered to keep the food as warm as possible. He said the staff refusing to warm up the resident's meal was a weird response. Nurse aide (NA) #2 was interviewed on 4/26/21 at 3:40 p.m. She said the protocol for delivering room trays would be to wake up the sleeping resident to see if they wanted to eat or not. She said she would leave the tray, but would check in again approximately one hour later. She said if the food had not been consumed, she would take the tray back to the kitchen. She said she did not know if all staff members offered the resident something to eat when he woke up. (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 0692 Level of Harm - Actual harm Residents Affected - Few	The DM was interviewed on 4/27/21 at 8:45 a.m. She said food could be reheated for up to thirty minutes after being served, but any food left out longer than 30 minutes should be dumped in the garbage. She said it was the CNAs responsibility to deliver and serve resident trays and stay to encourage the residents to eat. She said CNAs should be monitoring how long trays are being left untouched in the resident rooms. She said after she heard about Resident #14's room tray being left uncovered on his bedside table for several hours before he began eating it, she provided education to the nurse managers and said they needed to educate the CNAs about this issue. The registered dietitian (RD) was interviewed on 4/29/21 via telephone for a post survey interview, as she was out of town during the dates from 4/21/21 through 4/27/21. She said she expected to see a nutritional care plan for Resident #14, especially given he was receiving dialysis. She said Resident #14's potassium and phosphorus levels were within normal limits. She said he was not receiving a renal supplement, but was receiving Ensure. She said this resident did not follow his diet very well and liked peanut butter, which is not on his meal plan. She said she heard about the issue of this resident consuming a cold room tray and thought nurses reheated the resident's food for them. She said, once the DM heard about the issue, she provided the resident with a fresh meal. She said this issue may have happened more than once because that was the story she had heard. She said all facility staff, including herself, were responsible for obtaining accurate weights. She said she had no idea why a weight was not documented for Resident #14 during January 2021. She said she felt the DON should be taking lead on this issue because she was always in the building. She said she did her best to compare and request re-weighs when needed, but for some reason, those reweighs did not always get done. She said maybe the resident refused to be reweighed or maybe the scales were off, but it was a very challenging task to attempt to figure out what was actual weight loss, what was due to scale differentials or if weights were obtained from the hospital or physician's office. She said she tried her best to keep on top of everything else going on, such as how the residents are eating and if they are getting adequate assistance with their meals. She said it helped if the interdisciplinary team (IDT) could come together and discuss if it was actual weight loss or not. She said the IDT tried to get together regularly, but she felt there was a lot of back and forth emailing because not all team members can be together at the same time. She said she would email the DON, who responded with what was requested. She said she helped catch a lot of things and did what she could to help evaluate nutritional concerns. She said the DON was in charge of these issues, however. She felt it was more appropriate for the DON to monitor resident weights. She said she had no idea why the resident's weights varied. She said the scale issue was overwhelming and it had been a struggle for her. 26246 IV. Resident #20 Resident #20, age 72, admitted on [DATE]. According to the April 2021 CPO, diagnoses included osteoporosis, muscle weakness, history of falls and dysphagia (difficulty swallowing). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to the 3/3/21 MDS assessment, the resident was cognitively intact with a BIMS of 11 out of 15. She had moods to include poor appetite or overeating. She was independent with eating not requiring any staff help or oversight. She was 64 inches (five feet four inches tall) and 80 pounds. She was assessed to have weight loss of five percent or more in the last month or 10 percent or more in the last six months and not on a physician-prescribed weight loss regimen. A. Resident interview and observation The resident was interviewed on 4/21/21 at 11:08 a.m. She was lying in bed and was very thin and frail in appearance in her face, shoulders, clavicles and arms. She was edentulous and said that she had dentures but they did not fit her and she had not worn them for about [AGE] years. She said she did fine without them. She said she had lost a lot of weight and thought she weighed 75 pounds. She said the facility had talked to her about her weight loss and what could be done to help her. She said they tried the liquid supplements but she did not like them. She said she liked the chocolate ice cream they brought with her meals but it was always melted by the time it was served to her. She said she did not like to drink her ice cream. She said she would like to gain some weight back and would like to weigh 110 pounds. She said she used to weigh 145 pounds a long time ago. She said she did not like the facility food very much but did like some items. She said they slather gravy and cheese on everything. She said she really liked macaroni and cheese but the facility would not give her any I guess they won't give it to me because I said something about too much cheese. She said she told the facility she loved food from Taco Bell and McDonalds but that she could not get that from them. The resident had a partially eaten cherry pie on her overbed table and a carton of soda stored on the floor next to her bed. On 4/22/21 at 1:00 a.m. the resident still had her lunch tray in front of her. She said she did not like the egg salad sandwich and it was untouched. She also had a tomato slice and some pasta on the plate. She said she tasted both but did not like it. She said no one had checked in with her to see what else she would like to eat. On 4/26/21 at 11:36 a.m. the resident said she had not received scrambled eggs this morning for breakfast. She was served French toast and hot cereal. The resident said she had a few bites of the French toast. On 4/26/21 at 12:28 p.m. the resident's lunch tray was sitting in front of her. She had a sloppy [NAME] sandwich and fried potatoes. She said she did not like the taste of the meal. On 4/27/21 at 2:40 p.m. the resident still had her lunch meal on her tray in front of her. She said she had mashed up chicken inside a bun and it tasted nasty. She said it was dry and she had asked for mustard but never got any. She said she had a side of mashed potatoes and she ate those. She said her ice cream was melted, again when she got it. She had several packets of hot sauce from Taco Bell on her table. She said that one of the CNAs heard about her love of Taco Bell and she brought the sauce in for her and thought that was very nice. She said her favorite thing from there was the burrito supreme and the tacos. B. Record review (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Progress notes were reviewed from 2/1/21 to 4/28/21 and revealed the resident was documented with significant weight loss. Two entries found on 2/19/21 and 3/17/21 documented the resident was encouraged to eat in the dining room (ate most meals in room) and the resident verbalized she preferred to eat in her room. A 10/19/2020 admission nutritional assessment documented the resident's height was 64 inches and weighed 97 pounds and her body mass index (BMI) was 16.6. Her calculated total daily nutritional needs were: 1355 total calories, 44 grams of protein and 1322 fluids. She was documented as underweight based on her BMI and that the weight loss was unintended. She had a history of health decline and poor appetite. She dined in her room. She had no chewing or swallowing problems noted. Her nutritional plan was to honor her preferences and comfort focused care and that weight loss may be unexpected and unavoidable. She was to be offered snacks and hydration between meals as desired. A care plan initiated 10/22/2020 and revised on 11/5/2020 documented that while in the facility the resident would express by her words, smile, eyes and body language that it was important for her to have the opportunity to engage in daily routines that were meaningful to her. The goal was she would have the opportunity to make decisions/choices. Interventions included she liked to snack between meals and preferred microwave popcorn, Hershey kisses and peppermint patties. The 11/30/2020 nutritional assessment documented that an updated weight was requested and that her overall nutrient intake had improved. The plan was to continue with routine monitoring and to re-evaluate as needed if weight loss occurred, have supportive nutrition care to honor preferences and to provide balanced and healthy menu options. The resident's hospice care plan initiated 1/27/21 with a target date of 6/1/21, documented in pertinent part that the resident would be provided with food and fluids as desired for physical and emotional comfort. The 3/1/21 nutritional assessment documented the resident's BMI had declined to 14 from 16.6 upon admission (see significant weight loss note below). Her food preferences were re-evaluated and weight loss was discussed. The resident said she had a good appetite but did not like some of the foods, including the ground meats. She enjoyed hot sauce on her meats and hot sauce would be provided by the dietary manager. She continued to eat meals in her room. She enjoyed ice cream and was agreeable to try the frozen treat supplement for extra calories and protein. A nutritional care plan initiated 3/1/21with a target date of 6/1/21 identified the resident at risk related to low body weight, weight loss and decreased oral intake. The goal was she would remain comfortable during end of life and food preferences would be honored. Interventions included hot sauce would be provided by dietary, encourage the resident to chew and swallow each bite, provide diet as ordered, offer snacks between meals and provide house supplement frozen treat three times a day as ordered. A faxed note dated 3/4/21 from nursing department to the resident's primary physician requested a written statement to document that due to the resident being on hospice care, her weight loss was expected and unavoidable. The resident was placed in hospice care on 10/16/2020. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutrition note dated 3/12/21 documented the resident's weight was fluctuating between 79-82 pounds since 1/19/21 with a significant weight loss of 8.7 percent in 90 days. She ate her meals in her room. The resident would be provided with supportive and nutrition care to honor her preferences and to provide balanced and healthy menu options. The goal was comfort during end of life. A nutrition note dated 3/22/21 documented the resident's preferences were reviewed due to her complaint of the meals. The resident said she liked macaroni and cheese on a regular basis and cherry pie, chocolate ice cream and fast food. She was enjoying the hot sauce provided by dietary to flavor her ground beef. The dietary manager was notified of food preferences and they would try and accommodate them within the ability of the facility. The family was notified to bring in fast food if they were able. A physician visit note dated 4/13/21 documented the staff reported the resident was eating and drinking ok overall but she did not like the food she was served. The resident was frail in appearance and she was losing weight. The goals for her were palliative and she was on hospice care. The physician did not recommend[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40467 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff to ensure the residents received the care and services they required in keeping with their comprehensive plans of care, to achieve their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to ensure enough staff were available to adequately care for the residents activities of daily living (ADLs) were not met and addressed in a timely manner. Findings include: I. Facility policy The Activity of Daily Living (ADL) policy, revised 11/31/2020, was provided by the facility on 4/28/21. The policy read the facility must provide the resident the necessary care and services to ensure the resident's ADLs were maintained or improved. According to the policy, the resident's ADL's would not diminish unless circumstances of the resident's clinical condition demonstrated that change was unavoidable. II. Group interview The resident council was held on 4/21/21 at 10:00 a.m. with five residents. Four out of the five residents identified staffing concerns. One resident said she had to wait 30 minutes for someone to help her put on her sock. Three residents, in the council meeting, said they frequently had to wait for a certified nursing assistant (CNA) for care assistance to go to bed or receive nursing assistance for medications. One resident said her medications were about an hour later then they used to be. The resident said a couple times she had pulled her call light for pain medication and the CNA would answer the light and tell her she would inform the nurse but the nurse never came. She said the delay in medication through off her medication schedule. The resident said it was difficult to wait in pain. She said she since has informed management. According to one resident, call lights were starting to improve but she has had to wait an hour or two hours after pushing her call light. Another resident said she preferred to go to bed early but had to wait until midnight because of the slow staff response. Two of the residents said call light response was a problem after meals because the staff took their breaks at that time and there was no staff were available on the floor. They said it was difficult to get assistance at that time or request additional meal items after meal delivery such as creamer. According to the group, staffing also affected mail delivery. They said staff held mail and newspapers over the weekend because there was not enough staff to distribute it. III. Resident council minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The February 2021, March 2021, and April 2021 resident council minutes were reviewed. The March 2021 minutes identified staffing concerns addressed by the resident council. Concerns included linens not routinely changed, slow call light response and bathing inconsistencies. According to the March 2021 old/unfinished business, residents were not aware when the bathaide was available. According to the minutes, two of the residents had not received their scheduled Friday showers. Another resident frequently missed her Thursday scheduled bed bath. The minutes read a resident said the bathaide had been pulled to work the floor when CNAs needed help. IV. Resident call light and shower concerns Resident #27 was interviewed 4/21/21 at 10:13 a.m. She said the facility could use another CNA on 100 Hall. She said she usually went to bed between 7:00 p.m. and 8:00 p.m. She said on the evening of 4/19/21, she turned her call light on for assistance turning in bed and waited for several hours for assistance. She said her concerns with staffing occurred mostly during the night shift. She said an average call light response time during the days was 10-15 minutes. Resident #13 was interviewed on 4/21/21 at 11:01 a.m. He said he did not feel the facility had enough nursing staff. He said usually his call light was answered between 10-15 minutes and the longest he had to wait for assistance recently was thirty minutes. He said this long wait had occurred more than once because he required a Hoyer (mechanical) lift for transfers and often it was difficult to find a second person to assist with the transfer. He said some staff were just more responsive than others. He said he had found Mondays and weekends to be especially difficult days for staffing. He felt, at times, there was not enough staff working nights. He said he had never been harmed due to insufficient staffing, just very frustrated at times due to the long waits. Resident #10 was interviewed on 4/21/21 at 4:14 p.m. She said the facility was very short on certified nurse aide (CNA) staff, as the facility currently did not have two bath aides working the floor as was normal for the facility. She said since the facility had only been using one bath aide, she was no longer able to receive showers on Fridays as the facility no longer staffed a bath aide on Fridays. She said her doctor told her she needed to have at least three showers per week to assist in warding off recurrent urinary tract infections (not current). Resident #10 said an average call light response time was 15-20 minutes, but some time ago in the past year, she had to wait two hours for her call light to be answered. She said call light response time was worse right after meal times. She said often, after meals, she has observed a lot of staff going outside to take their breaks together instead of staggering staff breaks. She said it was also difficult at times to find staff to assist her to bed when she wants to turn in. She said she liked to go to bed earlier than most residents because of the pain in her leg. She said she has had episodes of urinary incontinence while waiting for her call light to be answered for assistance to the bathroom. She said once she was left on the toilet for quite a long time before her bathroom call light was answered for assistance off the toilet. She said her bottom had become numb before she was assisted off the toilet. Resident #12 was interviewed on 4/22/21 at 1:37 p.m. She said she did not feel comfortable showering at the facility. She said would rather bathe herself at the sink or have someone help wash up in her room or beauty shop (cross-reference F744 for dementia care and services). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #1 was interviewed on 4/26/21 at 8:53 a.m. She said the prior weekend staff were slow to respond to her call light. Resident #11 was interviewed on 4/27/21 at 8:48 a.m. She said had not had a bath or shower since 4/21/21. She said she was supposed to receive a shower every Monday, Wednesday, Friday and has already missed to shower days. She said she had not had a shower because the bathaide was working on the floor as CNA. Resident #11 said it was very important to be clean because of past and current medical conditions. -At 4/27/21 at 9:19 a.m. CNA #3 confirmed the bathaide had not given showers to all the residents in the hall because she had to help cover the floor. V. Staff interviews CNA #2 was interviewed on 4/21/21 at 11:52 a.m. She said there were a total of four residents in the 100 hall. She said the residents were provided bed baths, not showers. -Residents on the 100 hall were on an isolation unit for new admissions with COVID precautions. No confirmed cases or signs and symptoms COVID were identified. Nurse aide (NA) #1 was interviewed on 4/26/21 at 10:14 a.m. The NA confirmed it was custom for residents to only receive a bed bath while in the 100 hall instead of a tub bath or shower though none of the residents required two or more persons physical assistance in ADLs. She said the residents often would clean themselves with wipes. CNA #6 was interviewed on 4/26/21 at 10:38 a.m. She said there was not enough staff. She said, as the bathaide she was continuously pulled to work the floor and not able to to baths. She said Resident #106 had not had a shower since he was admitted . She said he was supposed to have one on 4/26/21 but did not because she worked the floor instead of a bathaide. CNA #6 said she should have received bed bathes when he was in the 100 hall. Nurse aide (NA) #1 was interviewed on 4/26/21 at 10:14 a.m. She said it expressed a need for more staff. She said in the 100 hall, there were times she needed a second person to assist with cares or a resident need, but she worked alone and the nurse was not always available. She said it had been a struggle to get additional help when needed. She said it would be helpful if there was another float CNA available on a regular basis. NA #1 said residents were routinely provided ice water but for residents who want to have juice or frequent coffee, they have to wait for a while or go without. She said she also worked in the 400 hall. She said need help to get out of bed and into the dining room. She said 300 and 200 halls were extremely busy all the time and could definitely use an extra person to assist with cares. Observation after immediately after the interview revealed the NA was not able to use the wall phone to call for a coffee request for a resident because she did not know the extension. Observation also revealed the nurse was not at the desk at the time if the CNA would need assistance with the resident request. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #6 was interviewed on 4/26/21 at 10:38 a.m. She said residents told her they are angry because they have to wait for assistance for care. She residents who were two person transfers had to wait too long for toileting or to be showered. She said she felt bad when she knew a resident had to go to a doctor's appointment but had not received a bath prior. The human resource director (HR) was interviewed on 4/26/21 at 10:50 a.m. She said that there was currently not enough staff available but they continue to try to hire more. She said all staff who were trained as a CNA, including herself, were working the floor to help provide coverage. The HR was interviewed again on 4/26/21 at 3:34 p.m. The HR said it had been very hard to find enough staff to fill the current positions. She said staff had done what they could to pick up shifts but it has been stressful. The HR said they currently have three CNA positions, two part time nursing positions and could use PRN (as needed) nursing and CNA positions to help with call ins and extra coverage. She said the facility currently had one open bath aide position. She said the current bathaid was covering Sunday through Thursday but there was not a CNA available for showers on Friday and Saturday unless other staff were available to do a few showers extra. The HR director said they have hired a social worker but she would not start for a few weeks. She said they had not had a social worker for over two month. She said staff turnover had been worse than ever in the past six months. She said when the census dropped with COVID-19, there were not enough residents to justify having the previous high numbers so full time staff only could work part time hours. She said many staff had to find other jobs in the community. The HR said facility was currently using two agency staff to help with coverage. She said many departments have had to pick up extra responsibilities to make up for the open positions. She said the facility has hired a nursing practice educator to start in a few weeks. She said the position would improve training and tracking. She said the assistant director of nursing was on leave which added to more responsibilities divided up among staff. The HR director said the current acuity levels of residents were very high and it had been hard and not fair on staff to try to cover a hall by themselves. She said there were more residents that were two person transfers with mechanical lefts and many of the residents had high care needs. She said the current labor budget would allow the facility to go back to two CNAs on each of the four halls once the census reaches 63 residents. She said right now with a census of 58 residents. She tried to make sure the 300 hall had at least a second aide, who would also float to other halls. CNA #3 was interviewed 4/27/21 at 10:14 a.m. She said she was tired. CNA #3 said she had been working alone in her hall for over a year and she had a lot of residents that required two person assistance. She said it was tough to provide all the resident care needs timely but was trying to get used to it. CNA #9 was interviewed on 4/27/21 at 10:41 a.m. She said she usually worked the 300 hall and had been exceptionally hard lately. She said many of the residents in that hall need lots of assistance. CNA #9 said she was often working by herself when staff had to help in the other halls. She said she often had to provide care to 22 residents by herself. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #12 was interviewed on 4/27/21 at 12:55 p.m. She said she did not think there was enough staff for the current care needs of the residents. According to the CNA, there was only one CNA for the 200 hall and all the beds were full. She said she tried to do as much as she could because she did not want to continue to have to tell the residents that she had to come back to assist them after she got help from another staff member in a different hall. She said the 200 hall and the 300 hall had the most residents that required a two person staff assist. CNA #12 said the 200 had seven residents that required a two person staff assist, and the 300 hall and eight to night residents required a two staff person assist. LPN #4 interviewed on 4/27/21 at 1:10 p.m. She said it was not feasible to keep all residents within a line of sight with the current staffing. She said she felt lucky to have at least one CNA for the 200 hall. She said toileting schedules went by the wayside and staff has not been able to respond to the residents quickly. She said the residents' depression had increased. She said the facility needed more staff to care for the residents Licenced practical nurse (LPN) #2 was interviewed on 4/27/21 at 2:18 p.m. She said the facility was short of staff and too much had been added to the existing staff. The LPN said she felt that she had done everything she could to cover all the responsibilities that had been placed on her. She said it had been too much for one nurse to do plus help the CNAs with ADL cares such as two person transfers because there were not enough CNAs. LPN #2 said resident acuity had increased, adding to more care needs and additional monitoring such as residents requiring full set vitals. She said responsibilities of the other departments, such social services, was now her job. The LPN said she now had to coordinate appointments, complete more residents assessments and admission paperwork, and update resident care plans were just some of her added jobs. The LPN said the facility increased staff responsibilities with less staff. She said tasks such in the monitoring and tracking of weights, following physician orders such as non-pharmacological interventions, and other routine nurse jobs could easily be missed because there was not enough time to do everything. LPN #2 said the facility needed a better system. Staff were doing everything they could manage but the facility needed a better system if they could not add staff. She said she worked 12 hour shifts and had many days she did not take a break. CNA #6 was interviewed again on 4/27/21 at 3:23 p.m. The CNA said she had not had enough help all month since the other bathaide started working as a regular CNA on the floor. CNA #6 said she was the only bathaide for the facility and felt more stressed to get all the showers and baths completed by herself. She said she was currently working 50 hours to cover all the bathing needs. She said she also helped as a floor CNA in addition to her normal job. CNA #12 was interviewed on 4/27/21 at 4:12 p.m. The CNA said the facility needed more staff. She said it was very hard to meet all the needs of the residents with the limited amount of help available. The NHA was interviewed on 4/27/21 at 4:55 p.m. He said the facility was currently focusing on call light timeliness. He said they wanted to ensure lights were answered quickly. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON and the NHA were interviewed on 4/27/21 at 7:43 p.m. They acknowledged staff felt an increase in stress when they had to be pulled into multiple directions. The NHA said the facility had an abundance of staff prior to COVID-19 but the sharp decline in the resident population during COVID-19 caused a decline in staff usage and availability. He said now that the resident census increased,, the staff were no longer available. The NHA said the facility has worked very closely with their corporate marketing office to recruit staff. Recruiting efforts included sign on and bonus referrals agency, digital ads, direct mail to people who were licensed to try to get them recruited on various job sites. He said they were making every attempt to improve staffing. The DON confirmed CNA #6 had been working up to 50 hours a week. The DON said it was the CNAs choice to work the additional hours for staffing coverage. VI. Record review A. Resident Census and Conditions of Residents report According to the Resident Census and Conditions of Residents report, the resident census was 58. The following high care needs were identified: -27 residents needed assistance of one or two staff members for toilet use and 18 other residents were identified as dependent. -21 residents were occasionally or frequently incontinent of bowel. -24 residents were occasionally or frequently incontinent of the bladder. -37 residents needed assistance of one or two staff members for dressing and 12 residents were dependent. -30 residents needed assistance of one or two staff members for transfers and 11 residents with dependant. -10 residents needed assistance of one or two staff members with eating and two residents were dependent. -30 residents needed assistance of one or two staff members with bathing and 28 were l dependent. -23 residents were diagnosed with dementia. -Three residents had an intellectual or developmental disability. B. Facility Assessment The facility assessment, last reviewed 1/20/21, read staffing was based on decisions made during staffing labor meetings, along with continued updates on resident care needs with additional considerations on upcoming new admissions. According to assessment, the facility strived for consistent staff-patient/resident assignments and tried to hire the community/hall he or she would work. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the facility assessment, one registered nurse and two licensed practical nurses would be scheduled from 6:00 a.m. to 6:00 p.m. The facility assessment revealed the facility should regularly adjust staffing levels according to needs to obtain sufficient staffing for direct care staff. C. Staff schedule The actual working staff schedule was reviewed between 4/20/21 and 4/26/21. According to the schedule, the facility had only two nurses covering the 6:00 a.m. to 6:00 p.m. shift on 4/23/21, 4/24/21, and 4/25/21 (as opposed to three nurses mentioned in the facility assessment above). On 4/25/21, the staffing schedule revealed only three CNAs worked on the day shift to take care of 58 residents, as opposed to a minimum of four CNAs as indicated by HR (see above). The review of the schedule identified staffing less than the facility deemed as the lowest the staffing should have based on census and acuity. 12905 31797

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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** 40467 Based on observations, record review and interviews, the facility failed to ensure two (#12, #203) of three residents reviewed for dementia care of 30 sample residents, received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to: -The facility failed to ensure Resident #12 was treated and spoken to in a dignified manner, had privacy and choice with her cares and had a plan of care on how to address her dementia, specifically refusal of bathing. -The facility failed to assess, identify, communicate and provide adequate dementia care for Resident #203 to ensure she received the highest practicable quality of life and care. Findings include: I. Facility policy and procedure The Considerate and Respectful policy, revised 7/01/19, was provided by the nursing facility administrator (NHA) on 4/28/21 at 4:12 p.m. The policy read in part: (The facility) will promote respectful and dignified care for residents in a manner in an environment that promotes maintenance or enhancement of his/her quality of life while recognizing each patient's individuality. According to the policy, staff was to interact with residents in a dignified manner to best support activities that support the resident in order to maintain and enhance their self esteem and self worth and incorporate the residents needs, preferences, and choices. The policy indicated the following as examples providing care with dignity. Examples included but not limited to: -Residents were groomed as they wished to be groomed; -Respect the residents by speaking respectfully; -Maintain the residents' privacy of body. The Dementia - Clinical Protocol policy, revised 2/28/21, provided by the facility on 4/28/21, The policy read in part: -Individualized, non-pharmacological approaches to care were utilized, including purposeful and meaningful activities addressing the resident's past customary routines, interests, preferences, and choices to enhance the resident's well-being; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document identified and targeted behaviors with consistent implementation of non-pharmacological behavior interventions and monitoring the effectiveness/resident response to the intervention to determine the next course of action. It is expected that the approaches to care for a resident with dementia follows a systematic care process in order to gather and analyze information necessary to provide appropriate care and services .The resident's record will reflect the implementation of development of care plan individualized approaches and treatments monitoring, follow and oversight of care plan implementation staff will receive education on care and needs of residents with dementia. According to the policy purpose was to: -Provide dementia care programs that were individualized, person-centered and relationship based; -Maintain the highest level of cognitive, physical, and activities of living (ADL) function; -Foster independence and promote non-pharmacological interventions. The ADL policy, revised 11/31/2020, was provided by the facility on 4/18/21. The policy read the facility must provide the resident the necessary care and services to ensure the resident's ADLs were maintained or improved. According to the policy, the resident's ADL's would not diminish unless circumstances of the resident's clinical condition demonstrated that change was unavoidable. The policy stated ADL care plans would address the resident's ADLs needs and provisions. II. Resident #12 A. Rsident status Resident #12, age 77, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included alcohol induced persisting dementia, anxiety, disorder, major depressive disorder and chronic obstructive pulmonary disease with acute exacerbation. The minimum data set (MDS) annual assessment was completed on 2/9/21. During the assessment a brief interview for mental status (BIMS) was conducted. The BIMs score was 14 out of 15, indicating the resident was able to make her needs known. Resident #12 required extensive assistance of one person physical assistance for bed mobility and dressing. She required extensive assistance from two or more persons for transfers. Resident #12 required limited assistance from one person for personal hygiene. The level of assistance for bathing was not identified. According to the MDS, the activity did not occur in the seven day look back period. B. Resident observation and interview (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/21 at 1:25 p.m. Resident #12 was observed in the hallway outside of her room. The resident said she was waiting for help and felt short of breath. Resident #12 had oxygen via nasal cannula. The call light was placed on. Certified nurse aide (CNA) #3 approached the resident. The staff member did not ask the resident why she needed assistance on approach. The CNA had the resident explain why she was not wearing shoes and socks. The CNA backed the resident's wheelchair up in the room and turned off the call light. CNA #3 started to walk around the resident's room, possibly looking in on the resident's roommate and looking for shoes and socks. After a couple of minutes in the resident's room without asking the resident why she called for assistance, the CNA was informed the resident felt she was short of breath. CNA #3 said Resident #12 did that sometimes. The CNA told the Resident #12 to take a few deep breaths, which slowed her down and was more at ease. CNA #3 exited the room. After the CNA left the resident said she hoped she did not have a real emergency here. -Observations revealed the CNA did not take a moment to allow the resident to express her needs.CNA #3 focused on the task she saw as the immediate need. -At 1:32 p.m. CNA#6 approached Resident #12 in the hallway outside of her room. The CNA spoke in a loud voice and told the resident that she needed a shower and it had been over a week since last bathed. The resident said no she did not want to be wet and cold again in the shower room. The CNA in an abrupt tone and loud enough for others to hear down the hallway, questioned the resident how she expected to get clean if she won ' t bathe. The resident shook her head and said no. The CNA told her in a joking tone the resident was causing her personal distress. CNA #6 walked away the resident and loudly told the nurse down the hall that Resident #22 (using the resident's first name), refused her shower again. Observations revealed that the CNA did not speak to the resident in a manner that would support her dignity. The CNA did not provide the resident privacy when she openly and loudly announced the resident had not had shower, continued to refuse a shower and implied the resident was not clean. The CNA did not address the resident's feelings and expressed needs of not wanting to feel wet and cold. CNA #6 focused on the problem with the resident and not the solution. She did not help the resident feel more comfortable in both the approach and a potential alternative. -At 1:37 p.m. Resident #12 interviewed a second time. She expressed frustration after the interaction with CNA #6. She said she did not have a problem with bathing when she was at home but did not want to have a shower here. The resident quietly said she did not want to feel wet, cold and naked in front of other people. She said would rather bathe herself at the sink or have someone help wash up in her room. She said when she was at home, she would go to the beauty shop to have her hair washed. She said she would like them to offer that to her at the facility. -At 1:38 p.m. licenced practical nurse (LPN) #2 reapproached the resident. The nurse spoke to the resident calmly and in private. The resident confirmed she refused because she did not want to feel exposed. LPN #2 attempted to provide reassurance of privacy and the resident said maybe another time. -At 2:06 p.m., Resident #12 was reapproached again to go to the shower room by LPN #3. The resident refused. Resident #12 was not offered an alternative to bathing in the shower room. C. Record review (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bathing record was reviewed on 4/27/21 at 8:58 a.m. According to the record, Resident #12 received a bath or shower on 4/1/21 and 4/5/21. The record indicated Resident #12 refused two offers of bathing. According the bathing record, Resident #12 refused a bathing or shower on 4/19/21 and 4/22/21. The record did not show she was offered an alternate bathing option such as a bed bath in her room. The activities of daily living (ADL) record was reviewed on 4/27/21 at 12:48 p.m. According to the record, the resident was offered a shower on 4/19/21 and 4/22/21, the resident refused both offers. The last recorded bath or shower documented was on 4/8/21. The record did not indicate the resident was offered bed baths after 4/8/21. The record did not show continued attempts to offer the resident bathing opportunities other than on 4/16/21 and 4/22/21. According to the record, Resident #12 did not have a shower between 4/9/21 and 4/25/21. The ADL care plan, initiated 2/2/21, read Resident #12 required limited to extensive physical assistance of one to two persons for bathing related to a recent illness, a fall, hospitalization , fatigue, activity intolerance and confusion. According to the care plan, her need would be anticipated and met throughout the next review period. -The care plan did not identify the resident's refusal of bathing or offered interventions to ensure the resident felt comfortable in the bathing process and had multiple bathing options. The preadmission screening and resident review (PASRR) care plan, revised 2/17/21, read the resident had major depressive disorder and dementia with behavioral disturbances. The psychosocial care plan, initiated on 2/8/21, read the resident was at risk for limited or meaningful engagement related to new to the facility, socialization, and desire to be recognized. Interventions included to provide the resident with opportunities of choice to promote a sense of control. The resident preference care plan, initiated on 2/8/21, read it was important for the resident to have the opportunity to engage in daily routines that were meaningful to her preferences. According to the care plan, preferences would be accommodated by staff. The care plan revealed that the resident would benefit from accommodations for her cognitive limitations by allowing time to process thoughts and respond. The care plan directed staff to offer verbal prompts when she lost her train of thought. -The review of the April 2021 care plan for Resident #12 did not identify a care plan specific to her dementia needs and behaviors. The care plan did not identify how staff should approach and interact with the resident to ensure she felt comfortable with her care needs. The care plan did not identify how staff could target and remedy specific behaviors and preferences, specifically bathing. The care plan did not identify the resident's need for privacy or how staff should treat the resident with respect and dignity. The facility failed to treat Resident #12, who has dementia, as a whole and support her with person centered interventions. D. Staff interview (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/27/21 at 12:09 p.m. She said if residents could refuse a shower but the facility needed to continue to encourage bathing and offer alternative solutions. The DON said it was important for the resident to feel comfortable with bathing. She said she could have been offered a bed bath and increased pericare. She said if the resident was concerned about being cold in the shower warm, she could receive showers later in the day when the room had a chance to warm up. She said she was not aware the resident felt exposed or embarrassed but that should be addressed at the first signs of distress. She said staff could ensure the privacy curtain was in place, limit those who enter the room and offer to turn their back if the resident was able to do some of her own washing. She said refusal of bathing should have been care planned with approaches to help the resident feel comfortable. The DON said staff should always try to use a calm soft voice and demeanor when interacting with residents, especially in private conversations and especially with residents with dementia. The residents should feel empowered and offered choices with their cares. The DON said staff are training on dementia communication through an online program. She said CNA's who provide bathing should also have Bathing with a Battle training. The DON said CNA #6 was the main bath aide for the facility and she was not sure if she received that training. -At 12:48 p.m., the DON reviewed the ADL tracking record. The DON confirmed the last shower documented was on 4/8/21. CNA #3 was interviewed on 4/27/21 at 1:46 p.m. She said has worked with residents with dementia for a long time. She said it was important not to talk down to a resident but simplify requests. She said it was important for staff to be positive, calm, supportive when interacting with residents with or out dementia. She said it was also to offer as much praise as possible to the residents to make them feel encouraged and comfortable. LPN #2 was interviewed on 4/27/21 at 2:14 p.m. She said the resident told her she felt exposed in the shower room on 4/22/21. The LPN said she did not know if the resident had accepted a shower since then but if she was continuing to refuse, new approaches should be implemented and shared with staff. CNA #6 was interviewed on 4/27/21 at 3:21 p.m. She said she had tried different times of day to offer a Resident #6 and shower but the resident continued to tell her that she will just wash at the sink. CNA #6 she would offer a bed bath if the resident requested it but it would take two staff to assist her with it. The CNA said she had not had help all month since the other bathaide started working only on the floor as a regular CNA. CNA #6 said she had been feeling more stressed recently to get all the showers completed. CNA #6 said she was not familiar with Bathing with a Battle'' but was requested to complete other trainings on 4/27/21 by management. The CNA said it was hard to speak to someone with dementia. She said she learned from the videos to offer choices and speak to them at their level. She said she could find incentives to encourage bathing and would learn how to run the sink in the beauty shop to wash the hair of Resident #12. She said the resident could have felt exposed in the shower if a staff member had to retrieve something out of the shower room or a laundry aide dropped off lift slings in the room. She said she would make sure no one entered the room when residents were showering. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and the DON were interviewed on 4/27/21 at 7:43 p.m. The DON said she reviewed dementia communication with CNA #6 and would provide the Bathing with a Battle training. The DON and the NHA were informed that CNA #6 was feeling stressed to complete all her responsibilities. E. Facility follow up The monitoring/supervision plan for CNA #6 was provided by the facility on 4/27/21 According to the plan, CNA #6 would view the Bathing with a Battle video and complete a series of dementia modules. The plan indicated if CNA #6 verbalize feelings of frustration, she would be asked to take a break. The training record for CNA #6 was provided by the facility on 4/27/21. The training record indicated the CNA was provided training on dementia care safety and positive dementia communication. The NHA provided an updated ADL record on 4/30/21 via email. According to the record, Resident #12 was provided a tub on 4/26/21. 12905 III. Resident #203 A. Resident status Resident #203, age 84, was admitted on [DATE]. Diagnoses on the April 2021 computerized physician orders included dementia without behavioral disturbance, repeated falls and unsteadiness on feet. The minimum data set (MDS) assessment had not yet been completed due to the resident's new admission status. According to nursing admission notes, on 4/20/21 at 2:30 p.m., the resident had severe cognitive impairment, and had difficulty making her needs known without prompting. Her balance was unsteady and her speech was unclear. B. Family interview Resident #203's daughter was interviewed by phone on 4/22/21 at 10:15 a.m. She said the resident was just admitted , and she thought the resident probably had depression. She had lived with her daughter for eight years before moving into the facility. She said she was asked to not visit the facility for a while to allow Resident #207 to adjust to her new environment. She had not been invited for a compassionate visit or informed of the possibility. She said the resident had pain to her right shoulder and bad arthritis that was painful. Review of the nursing admission notes (see below) indicated the family member was not present for the resident's initial nursing assessment. C. Observations The resident was observed on 4/21, 4/22, 4/26 and 4/27/21. She was often agitated, confused and tearful, saying she was looking for my people, and wanting to go home. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/26/21 at 12:40 p.m. Resident #203 was heard from the hall softly calling out for help. No staff were around. Upon entering her room she was observed standing over her bed unsteadily, with her hands on her bed. She was distressed, almost tearful and slightly out of breath. She could not say what was wrong and was encouraged to sit to catch her breath and steady her balance. The call light was not visible or within her reach. When asked if she knew where her call light was for assistance, she tearfully said no. Her call light was found on the back side of the curtain between her roommate's dresser and Resident #203's curtain, up against the wall on the floor. She was provided the call light and she appeared frustrated when the location of the call light was shared, upturning and slightly shaking her head, and opening her mouth in surprise. She pushed the button. In less than a minute LPN #3 entered the room and asked Resident #203 what she needed in an impatient tone. LPN #3 was asked what Resident #203 needed. She said Resident #203 could not tell her on attempt or forgot, and then told LPN #3 nevermind. She said she saw that the resident could be positioned better in bed and provided assistance. The nurse said she told the resident to push the call light if she remembered what she needed from her. LPN #3 said the resident had a difficult time communicating and was very unsteady on her feet. She said it was important that Resident #203 had the call light within reach of her when in her room because she was unsteady. (This was an unsolicited response to the call light as she was not aware of the observation.) LPN #3 said it was not safe for the resident to pick up items off the floor. On 4/27/21 at 8:34 a.m. Resident #203 was standing in the doorway to her room, unsteady, holding a styrofoam glass with a straw, wearing gripper socks. She was tearful, saying she just wanted to go home. A CNA observed how unsteady she was, said she'd be right back, and encouraged the resident, who gratefully accepted, to sit down in her wheelchair. Without further engaging her, the CNA walked away. At 10:18 a.m. Resident #203 was in her wheelchair in the hallway, wheeling in and out of her room, unengaged. There were no staff around except the maintenance director, who was cleaning ceiling vents. On 4/27/21 at 10:35 a.m., Resident #203 was observed waving down LPN #3 for assistance. The nurse approached the resident with her hands on her hips and asked her what she needed. The resident attempted to speak but LPN #3 quickly said to the resident that she needed to tell her what she needed so she could help her. The resident said, I can ' t. Resident #203 began to cry. The LPN told the resident she would come back to her in a moment. At 10:37 a.m., LPN #3 returned to the resident. The LPN repeatedly told the resident to tell her what she needed and she did not need to cry. Resident #203 said to the nurse that she needed help. LPN #3 said With what? twice and use your words. Resident #203 reached for LPN's hand and said tearfully that she did not know. The LPN told the resident she needed to touch her nicely. The resident retracted her hand and the LPN took the resident to her room, telling her that her daughter wanted her at the facility so she could be safe. The LPN continued the conversation with the resident in her room. LPN #3 was interviewed on 4/27/21 at 10:46 a.m. The LPN said she believed the resident was just homesick because she continued to try to pack up her items. LPN #3 said Resident #203 had dementia and it was important to use clear, concise, and simple instructions when interacting with her. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note by the therapy director/occupational therapist dated 4/23/21 at 10:34 a.m. documented, Called daughter . to ask permission to utilize a walker provided by the facility for functional mobility rather than the 4WW she admitted with. She agreed with clinical judgment of PT/OT to assess for use of U-step vs FWW moving forward and may be by this afternoon to pick up the walker. Communicated this with the front office, and that the walker is in the gym with the resident's name on it. A nursing note dated 4/24/21 at 2:30 p.m. documented Resident cried a lot wanting to go home. Always has been redirected. Tendency to stand up leaving walker or wheelchair behind her. A nursing note dated 4/24/21 at 10:30 p.m. documented, Resident is a high risk for fall. Safety measures observed by reminding the resident to always use her walker or wheelchair. Needs are met. On 4/26/21 at 6:30 a.m., Resident is A/Ox1 and is unable to clearly make her needs known. She is easily frustrated by staff not being able to immediately identify her needs. She has extreme difficulty finding the words for whatever she needs. On 4/26/21 at 2:36 p.m., the MDS coordinator documented she attempted an interview with Resident #203. Does not understand question regarding pain level and periods of pain, demonstrated pain assessment grid, no verbal response. She was able to repeat 1 word on BIMS but could not recall, nor did she know month, week, day. Staff interviewed (LPN #3 and CNA #8). Resident ambulates in hallway with no purposeful destination, will turn around in hallway per self with limited stand by assist due to unsteady gait. Therapy request to assessment correct walker. Staff stating she cries easily and is not easily redirected during these episodes, does not appear in pain, no protected body movements, facial grimacing secondary to crying episodes. She is pleasant during this encounter. On 4/26/21 at 4:25 p.m., the DON documented, Call placed to daughter and talked with her about her mother's adjustment to facility. She stated that she told the staff that she was going to hold her visits off for a while and give her mother a chance to adjust to a new setting. She said she did discuss with daughter that we have compassion visits available as well if she is asked to come see her mother to help her with support from someone she knows. Daughter stated that she was planning to schedule a visit in the next two days. Will continue to offer support to resident. On 4/27/21 at 6:30 a.m., .has difficulty making her needs known. She has required in depth conversations to have her needs be known. She has been tearful and frustrated today with the inability to make her needs known clearly. Staff was eventually able to figure out what she needed, but she was very frustrated by the end of it. The resident was documented to have 5/10 moderate pain unable to answer, unable to describe or determine what makes the pain better or worse. On 4/27/21 at 12:16 p.m. she was again documented with 5/10 pain, which she was unable to describe, and When asked if she is in pain, resident states no. -Although the resident had an order for as-needed Acetaminophen, two 325-mg tabs, review of her medication administration record revealed she was given nothing for her 5/10 pain. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/27/21 at 12:22 p.m., Resident has been very tearful and frustrated again today. She is unable to state what she needs without extensive prompting. On one occasion, we figured out that she was trying to say she needs to get out of here, as well as saying that she needs her family. Resident was also aggressively grabbing this nurse's hand, and she needed reminders to touch people gently. She is unable to be redirected besides occasionally with snacks. (This was documented by LPN #3, who had documented all the nursing notes for Resident #203 on 4/27/21 - see observation above and interview below.) On 4/27/21 at 2:10 p.m., the admission director documented she called Resident #203's daughter regarding visitation. The daughter was agreeable, and referred to the gals upfront who schedule to call her back. On 4/27/21 at 5:01 p.m., the AD documented, This writer gave (Resident #203) a small plastic tub with 4 clean hand towels and 4 clean washcloths. I asked her if she would fold them for me and she was very agreeable and willing to complete this task. I assisted in pushing her into the activity area and up to a table with a view of the outdoors, put the item on the table and (resident) began folding and appeared very content with this task. E. Staff interviews The therapy director was interviewed on 4/27/21 at 9:40 a.m. She said Resident #203 was admitted with a front wheel walker which was really scary; she doesn't remember to engage her brakes and will spontaneously stand. She needs assistance with all her ADLs related to cognition more than anything. We were able to get her a wheelchair - I want to say it was within 48 hours. Nursing could've grabbed a wheelchair for her right away; a lot of residents have orders for wheelchairs. I emailed (nursing staff) the day I got her the wheelchair and asked staff to keep her in line of sight, and keep her engaged, but staffing is a problem. I think compassionate visits would help. CNA #9 was interviewed on 4/27/21 at 12:45 p.m. regarding Resident #203's care. She said her care for Resident #203 involved, Keep an eye on her, get her out of her room, take her to activities, have her call her daughter. I think that makes her less upset. Resident #203 was trying to get herself into bed when CNA #9 and CNA #12 encouraged her to sit in her wheelchair. CNA #9 said she had taken Resident #203 to the bathroom just before lunch. As the second CNA was trying to take Resident #203 down to the bird aviary, she got upset and wanted to go back into her room. CNA #12 was interviewed at about 12:55 p.m. She said her care for Resident #203 involved, Encourage her to attend activities to keep her safe, provide assistance, ask if she (needs the bathroom), I may sit and talk with her for a little while, try to redirect her to something she may enjoy doing. Sitting with her sometimes helps a lot . I feel so bad because she cries a lot. She's fairly new here so I think it's a huge transition. She was living with her daughter and her daughter couldn't handle it so she moved here. I try to check, at least see her, every hour because I'm doing vitals on all the halls, helping with various transports for all the residents, I'm everywhere. CNA #12 said she had not attended dementia care training at the facility, and had worked here for a little over a year. I don't think we have enough staff for what we have here. We all do our best. We just have one staff for this hallway and it's full - there's way too much for what we have. I try my hardest to help. Are we getting needs met for (Resident #203)? Probably not, but I do what I can. (Cross-reference F725 sufficient nursing staffing.) (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 4/27/21 at 1:10 p.m. Regarding Resident #203, she asked, Why are you guys so interested in her? Just curious. We have a hard time meeting her needs because we don't know what they are, because she has a hard time expressing them to us. She gets frustrated and tearful. Her care plan is something I'd have to look up. As a general rule for residents, we try to find out what the needs are. She gets so frustrated so I tell her take a deep breath, I have time for you, what can I do for you, what do you need? Sometimes it's one-word answers and I try to guess: hungry? cold? show me? We try to incorporate her into Garden Room activities, get her to meals so it's more like a routine. She said she was unfamiliar with the facility's dementia care protocols, and would have to look them up. She thought dementia care involved redirection, reorientation, and reminding residents why they lived in the facility. She said they were still trying to figure out Resident #203's baseline, and how to meet her needs as an individual. Her daughter was her main caregiver and is going to hold off on visiting for a while so she can get adjusted, and said she can make her needs known, which isn't quite the case. I'm sure her daughter knows her much better than we do and can anticipate more of those needs. Like when you have a two-year-old [TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31797 Based on observations, record review and interviews, the facility failed to ensure consistent behavior monitoring was conducted for target behavior related to the use of psychotropic medications for four (#33, #4, #12 and #51) of five residents reviewed for medications of 30 sample residents. Specifically, the facility failed to ensure: -Target behaviors were being tracked for the use of Abilify (an antipsychotic medication) and Buspar (an anti-anxiety medication) for Resident #33; -Obtain a consent for the use of Abilify from Resident #33 or the resident's representative; -Provide PRN Ibuprofen before as needed (PRN) Oxycodone for Resident #12 as indicated in the physician's orders; -Provide and document non-pharmacological interventions before PRN pain medication for Resident #12 and Resident #4; and, -Track hours of sleep with use of a psychotropic for Resident #51 as indicated in the physician's orders and attempt a gradual dose reduction of the medication. Findings include: I. Facility policy and procedure The Psychotropic Medication Use policy, revised 11/28/16, was provided by the director of nursing (DON) on 4/27/21 at 8:30 a.m. It documented facility staff should take a holistic approach to behavior management that involved a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. It documented the facility should involve the resident or the resident's representative (s) in the discussion of potential non-drug and medication interventions to address the management of behaviors and the involvement should be documented in the resident's medical record. The policy documented psychotropic medications may be used to address behaviors only in non-drug approaches and interventions were attempted prior to their use. It documented facility staff should monitor the residents' behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication. It documented facility staff should monitor behavioral triggers, episodes, and symptoms. It documented facility staff should document the number and/or intensity of symptoms and the resident's response to the staff interventions. II. Resident #33 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #33, age 60, was admitted on [DATE]. According to the undated face sheet, diagnoses included major depressive disorder, recurrent, unspecified and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The minimum data set (MDS) assessment dated [DATE] documented the resident scored 14 out of 15 for a brief interview for mental status (BIMS) assessment, which meant he was cognitively intact for daily decision making. It documented the resident reported he felt bad about himself or that he was a failure for seven to 11 days during the 14-day lookback period. This was his only reported symptom of a mood disorder such as depression. It documented he displayed no indicators of psychosis. It documented he displayed no physical behaviors, no verbal behaviors or any other behaviors symptoms not directed towards others. He displayed no rejection of cares and no wandering. The MDS documented Resident #33 received seven days of antipsychotic medication, seven days of anti-anxiety medication and seven days of antidepressant medication during the seven-day lookback period. It documented the resident received his antipsychotic medication on a routine basis only. B. Record review 1. Care plan The care plan dated 3/25/21 related to psychotropic medication use was reviewed. It documented Resident #33 was at risk for complications related to the use of psychotropic drugs. Interventions included monitoring for changes in mental status and functional level and report to the medical director as indicated, monitor for continued need of medication as related to behavior and mood, monitor for side effects and consult physician and/or pharmacist as needed and provide informed consent to resident or healthcare decision maker. 2. Physician orders The April 2021 computerized physician orders (CPO) documented Resident #33 was ordered, in pertinent part: -Aripiprazole (Abilify), 5 mg QD (every day). This antipsychotic medication was ordered on 3/12/21 for antipsychotic/antimanic and changed to use for major depression on 4/8/21. -Lexapro (an anti-depressant medication), 20 mg QD. This was ordered on 3/12/21. -Buspar (an anti-anxiety medication), 5 mg BID (twice a day). This was ordered on 3/11/21. 3. Consents for psychotropic medications The consents for Lexapro and Buspar were completed and signed by the resident's son/MDPOA on 3/11/21. -However, there was no consent seen for the use of Abilify, which was ordered on 3/12/21 and carried a black box warning. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Behavior monitoring records No behavior monitoring forms were seen in the resident's electronic chart since the resident was admitted on [DATE]. There were no target behaviors seen in the chart for the use of psychotropic medications. 5. Progress notes The following were the only progress notes in Resident #33's electronic medical chart which related to behavior monitoring: -The progress note dated 4/15/21 documented anxiety about the resident's surroundings and loss of interest for five days this week and also noted the resident exhibited frustration. -The progress note dated 4/19/21 documented the resident was alert and oriented times three and was able to make his needs known. No progress notes were seen in the record addressing target behaviors for the use of psychotropic medications, potential side effects for these medications, non-pharmacological interventions attempted prior to medication administration or if the use of psychotropic medications had been effective or ineffective for this resident. 6. Physician notes There were no physician notes in the resident's electronic records which specified the specific rationale for prescribing an antipsychotic, antidepressant and anti-anxiety medication for Resident #33 or the target behaviors being addressed by the prescribed medications. 7. Additional records The March and April 2021 medication administration records (MAR), provided by the director of nursing (DON) on 4/26/21 at 8:29 a.m. documented the resident had been receiving Aripiprazole/Abilify routinely since 3/12/21. The pharmacist consultation report dated 2/1/21 through 3/16/21 documented Resident #33 had current orders for Abilify, 5 mg daily. The attached diagnosis was antipsychotic/antimanic. The primary care physician signed this document on 3/31/21. The director of nursing signed this document on 4/7/21. D. Staff interviews The DON was interviewed on 4/26/21 at approximately 8:15 a.m. She said the facility did not use behavior monitoring forms. She said the facility charted by exception in their progress notes and this included behavior monitoring for the residents on psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #3 was interviewed on 4/26/21 at 2:20 p.m. She said the facility did not track residents receiving psychotropic medications on a regular basis; they just put the documentation in prn (as needed) notes. She said the MAR triggered them to answer if there were any side effects for those medications each shift, but there was no mechanism to routinely track target behaviors for those medications, effectiveness of those medications each shift or non-pharmacological interventions attempted prior to administering psychotropic medications. She said the treatment administration record (TAR) triggered them to look at non-pharmacological interventions for things like pain, but not psychological issues. She said she felt the facility would benefit from using a behavior monitoring sheet each shift so all these questions could be addressed at a glance to determine the medication's effectiveness or not. She said there was no way to monitor if medications were necessary or effective without these questions being answered routinely. She said this was especially important given the facility did not currently have a full-time social services director (SSD) worker presently. She said she did not know if the SSD monitored and reviewed those forms in this facility or not. The DON was interviewed again on 4/26/21 at 2:45 p.m. She said Resident #33 had been admitted on Abilify, but was uncertain how long the resident had been taking this medication prior to admission. She said she did not see a signed consent for the use of Abilify for Resident #33, but it was her expectation for the facility to have one. She said it was the responsibility of the admitting nurse to ensure those consents were signed. She said she would have expected to see more detailed behavior monitoring documented for a new resident on an antipsychotic medication rather than just the two progress notes documented in the record since the resident had resided in the facility. The NHA was interviewed on 4/27/21 at 5:54 p.m. He said he had been made aware of the issue related to behavior monitoring for residents receiving psychotropic medications. He said he has reached out to his regional and corporate offices, who were piloting a new digital behavioral monitoring program for their electronic records, which included providing certified nurse aides with computer tablets so they would be able to document behaviors in real time. He said with this program they could specify a specific target behavior to document on. He said the facility would be receiving corporate training related to this issue on 5/5/21. He said the facility needed to be able to see the big picture when it came to monitoring residents and the psychotropic medications they received. He said if the facility had this computerized program, they could just pull individualized reports to use when they conducted their gradual dose reduction meeting. He said it would also be very beneficial information to have for the resident's care conferences. 40467 III. Resident #12 A. Resident #12 status Resident #12, age 77, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included alcohol induced persisting dementia, anxiety, disorder, major depressive disorder and chronic obstructive pulmonary disease with acute exacerbation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The minimum data set (MDS) annual assessment was completed on 2/9/21. An assessment for a brief interview for mental status (BIMS) was conducted. The BIMS score was 14 out of 15, indicating the resident was able to make her needs known. Resident #12 required extensive assistance of one person physical assistance for bed mobility and dressing. She required extensive assistance from two or more persons for transfers. Resident #12 required limited assistance from one person for personal hygiene. The MDS identified the resident had pain. According to the pain assessment for Resident #22, pain was present and frequent. The MDS indicated the resident limited her day to day activities because of pain. The MDS revealed Resident #22 received PRN (as needed) pain medications without a non-medical intervention for pain. The resident had an order for Oxycodone HCl, Ibuprofen, and Tylenol for pain management. B. Record review The pain care plan, initiated 2/2/21, read Resident #12 exhibited or was at risk for alterations in comfort related to musculoskeletal disorders. Interventions included to medicate as ordered for pain. The April 2021 computerized physician order (CPO), read Resident #12 had an order of Oxycodone HCl tablet at five milligrams (MG), initiated on 2/2/21. The Oxycodone was scheduled every four hours as needed for moderate pain. There was a black box warning with this medication that read the resident had an allergy to the medication. The April 2021 CPO indicated Resident #12 had an order for an Ibuprofen tablet 400 MG, initiated on 2/15/21. The order read to give one tablet by mouth every 8 hours as needed for back pain. According to the order, the physician directed staff to use Ibuprofen before trying Oxycodone. The April 2021 the medication administration and treatment record (MAR/TAR) was reviewed. According to the MAR, Oxycodone was used 18 times between 4/1/21 and 4/26/21. The MAR indicated Ibuprofen was not offered to Resident #12 between 4/1/21 and 4/26/21. -The MAR revealed the physician's order to use Ibuprofen before trying oxycodone for pain management was not followed. The April 2021 CPO indicated Resident #12 had an order for non-pharmacological interventions, initiated 2/2/21. The order read: Non-Pharmacological Intervention(s) used before PRN. Pain medication or before PRN antidepressant, anti-anxiety, anti-psychotic or sedative/hypnotic medication document by number:1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction 9 toilet 10 ambulate 11 provide food/drink 12 educated 13 one:one 14 other. The order directed staff to use non-pharmacological interventions used before PRN (as needed) pain medication of oxycodone. The April 2021 MAR/TAR was reviewed for non-pharmacological intervention use prior to PRN pain medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The MAR/TAR revealed non-pharmacological interventions were not used prior to the administration of Oxycodone. -The review of the medical record did not indicate physician's orders were followed as directed. IV. Resident #4 A. Resident status Resident #4, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2021 CPO, diagnoses included Alzheimer's disease, dementia with and without behavioral disturbances, and type two diabetes with neuropathy. The minimum data set (MDS) assessment was completed on 1/18/21. The BIMS assessment was attempted but could not be completed by the resident. According to the MDS, the resident's cognition was moderately impaired with short term and long term memory loss. The review of the MDS identified Resident #4 required extensive assistance of one person physical assistance for bed mobility and dressing, tolietling, personal hygiene and transfers. Resident #4 was independent with set up for eating. The MDS identified the resident had pain. According to the pain assessment for Resident #4, pain was present and almost constant. The MDS indicated the resident limited her day to day activities because of pain. The MDS revealed Resident #4 received PRN pain medications without a non-medical intervention for pain.The resident had an order for Tramadol pain management. B. Record review The pain care plan, revised 3/24/21, read Resident #4 exhibited or was at risk for alterations in comfort. Interventions included to medicate as ordered for pain. The activities of daily living (ADLs) care plan, revised 3/24/21, directed staff to attempt non-pharmacological interventions to alleviate pain and document effectiveness. The April 2021 CPO, read Resident #4 had an order for Tramadol HCl tablet at 50 MG, initiated on 6/10/2020. The Tramadol was scheduled every eight hours as needed for pain. The April 2021 CPO indicated Resident #4 had an order for non-pharmacological interventions, initiated 2/2/21. The order read to use non-pharmacological intervention(s) before PRN (as needed) pain medication and document intervention. The April 2021 the MAR/TAR was reviewed. According to the MAR, Tramadol was used on 4/12/21, 4/13/21, 4/21/21 and 4/23/21. -The MAR/TAR did not indicate non-pharmacological interventions were used prior to the medication. -The review of the medical record did not indicate physician's orders were followed as directed. V. Resident #51 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #51, age 88, was admitted on [DATE] with readmission on 5/11/2020. According to the April 2021 computerized physician orders (CPO), diagnoses included dementia without behavioral disturbances, anxiety disorder, mood disorder with depressive features, and chronic obstructive pulmonary disease with acute exacerbation. The minimum data set (MDS) quarterly assessment was completed on 4/8/21.The resident had a BIMs score of 15 out of 15, indicating the resident was cognitively intact. The MDS indicated Resident #51 was independent with his ADLs. The MDS identified the resident received an antidepressant medication seven days a week. The MDS did not identify if a gradual dose reduction (GDR) was attempted. B. Record review The psychotropic drug use care plan, last revised on 6/9/19, read Resident #51 was at risk for complications related to the use of a psychotropic drug medication. Interventions included to monitor for side effects of the medication. The care plan indicated to conduct a GDR as ordered. The April 2021 CPO, read Resident #51 had an order for Celexa at 10 MG, initiated on 9/29/2020. The order read to give one tablet by mouth one time a day related to mood disorder due to known physiological conditions with depressive features. The April 2021 CPO, read Resident #51 had an order to document hours of sleep secondary to psychotropic use, initiated 3/24/19. -The review of the resident's medical record did not indicate hours of sleep were documented while a psychotropic was in place. The medical record did not indicate the physician's order was followed as directed. The interdisciplinary team (IDT) progress note 3/16/21 identified the resident has less outbursts and was functioning well. The IDT recommended the regimen remain in place. Review of the medical record did not identify a GDR was attempted for Celexa. The medical record did not identify a GDR was contraindicated. VI. Staff interview The director of nursing (DON) was interviewed on 4/27/21 at 12:11 p.m. The DON said physician's orders were to be followed by staff. According to the DON, non pharmacological interventions and medication administration were documented in the MAR/TAR. The DON reviewed the MAR/TAR and the physician orders for Resident #12. She confirmed Ibuprofen should have been used before the PRN Oxycodone. She confirmed non-pharmacological interventions should have been attempted and documented before the administration of the PRN Oxycodone for Resident #12. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said non pharmacological interventions should have been attempted and documented before the PRN administration of Tramadol for Resident #4. The DON said the physician order to document hours of sleep with use of a psychotropic for Resident #51 should have been done for Resident #51. The DON reviewed the documentation and did not identify Resident #51's hours of sleep were tracked. The DON said incorporating non pharmacological interventions with documentation if other methods should have been incorporated to attempt alleviate the pain before need for additional medication for Resident #12 and Resident #4 because a person's body was better off with less medication when possible. Tracking of hours of sleep was necessary for Resident #51 to determine if his psychotropic negatively affected him as a side effect of increased sleep. The DON said the assistant director of nursing (ADON) was currently on leave and would have normally assisted in the monitoring of the processes. She said she and the weekend manager train all the nurses on the importance of following physician's orders and administration and documentation of non pharmacological interventions. Licensed practical nurse (LPN) #2 was interviewed on 4/27/21 1:59 p.m. She said she was not that Resident #51 had an order for documentation of hours of sleep. She reviewed his documentation and confirmed his sleep hours were not tracked. She said she was not currently providing and documenting non pharmacological interventions prior to the identified medications for Resident #12 and Resident #4. She said she was not aware it was on the physician's order to do. The LPN said she did the best she could with the time she had to review medications orders but was pulled in too many directions because the facility was short staffed.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26246 Based on observations, record review and interviews, the facility failed to ensure that all drugs and biologicals were properly stored in one of three medication carts. Specifically, the facility failed to ensure: -Multi-dose medications were labeled with the date of opening; and; -Resident specific insulin pens were dated when opened in order to identify when the medications should be removed from service. Findings include: I. Facility policy The Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy, last revised 10/16, was provided by the nursing home administrator (NHA) on 4/27/21 at 2:30 p.m. The policy documented in part, Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened . II. Professional reference According to Humalog Kwikpen (4/2020) [NAME] Lilly and Company, retrieved 5/2/21 from http://pi.lilly.com/us/humalog-kkwikpen-um.pdr, Humalog Kwikpen insulin, Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen. According to the Novolog FlexPen package insert, retrieved 5/2/21 from: https://www.novo-pi.com/novolog.pdf, A single patient use Novolog FlexPen of 3 (milliliter) ml which has been opened and in use is good for 28 days. According to the Joint Commission's expectations for multi-dose, single resident use, vials, retrieved 5/2/21 from https://jointcommision.org, and last updated March 2017, Multi-dose vials are to be discarded 28 days after first use. III. Observations and interview On 4/26/21 at 3:50 p.m. medication cart #3 was observed for expired medications with registered nurse (RN) #1. The cart contained the following: -Two Humalog insulin multi-use vials opened, in use and undated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One Humalog insulin kwikpen, open, in use and undated. -One Novolog insulin flexpen, in use and undated. -One Lantus Solostar insulin pen, in use and undated. RN #1 said that when an insulin vial or pen was opened it must be dated and they expired in 30 days once opened. She said it was important to date the vials so that they know when to throw them away. IV. Additional interview The director of nursing (DON) was interviewed on 4/27/21 at 2:00 p.m. She said that all insulin vials must be dated once they are opened so that they can be tracked. She said some were good for 28 days and others were good for 30 days once opened. She said some may lose their strength and no longer be potent.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on resident interviews, staff interviews, record review and the tasting of test trays, the facility failed to consistently serve food that was palatable, served a proper temperature and adhered to resident preferences for residents residing in four out of four units. Specifically, the failed to ensure: -Room trays were served warm; -Meals were appetizing in taste; -Meals were well balanced; and, -Resident preferences were recognized and accommodated. Findings include: I. Facility policy The Quality and Palatability policy, revised September 2017, was provided by the nursing home administrator (NHA) on 4/28/21. The policy read in part: Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. II. Resident interviews Resident #27 was interviewed on 4/21/21 at 10:18 a.m. She said they always overcooked the fish. She said she had lost quite a bit of weight recently due to the taste of the food served and she preferred the food that her daughter brought her. -On 4/26/21 at 11:50 a.m., Resident #27 was observed in the dining room eating the stuffed peppers that her daughter made for her and brought into the facility for her mother. -On 4/27/21 at 11:50 a.m., the resident was observed in the dining room eating the meal her daughter prepared, as well as a Frosty from Wendy's. Resident #33 was interviewed on 4/21/21 at 11:04 a.m. This resident was ordered a pureed diet. He said, many times the puree was tasteless, especially the bread and the vegetables. He said the fish was much too dry and overcooked. -On 4/26/21 at 12:50 p.m., Resident #33 said the sausage he had for lunch was too spicy for his taste and that he was not served a dinner roll. Resident #21 was interviewed on 4/21/21 at 10:47 a.m. She said she did not like the food and felt there was not enough variety of meat. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 was interviewed on 4/21/21 at 12:52 p.m., he said the facility did not season any of their food sufficiently, especially related to the use of salt and pepper. He said the food always tasted very bland to him. -On 4/26/21 at 12:45 p.m., a sack from Arby's was observed on Resident #40's bedside table. He stated his daughter brought him some sandwiches. He stated that he preferred fast food to the food the facility served. Resident #11 was interviewed on 4/21/21 at 3:16 p.m. Resident #11 said she was diabetic and the current menus contained too much starch and not enough fruits and vegetables. She said most of the fruit served was canned peaches and pears. Resident #1 was interviewed on 4/21/21 at 4:15 p.m. She said the food was sometimes not warm enough when served on a room tray or prepared in a manner that tasted good. Resident #1 said she has difficulty with her preferences of food honored. She said she had expressed when she did not like particular meal items but then continued to be served those items. (Cross-reference F561 Choices) Resident #10 was interviewed on 4/21/21 at 4:23 p.m. She said for the past two months the facility had been serving powdered creamer instead of the liquid creamer the residents liked. She said the problem was sometimes the coffee served with the resident room trays was so cold, the powdered creamer would not dissolve in the coffee. She said the residents used to receive a paper menu for each meal describing the main meal and the alternate meal. She said recently, the facility stopped that practice and had just been bringing all residents the main meal and they no longer got to choose between the two entrees. She said if a resident did not care for the meal, they could have it sent back and receive something from the always available menu, like some type of sandwich. She said she felt this was a waste of food. She said the kitchen had served meat, vegetables and especially French fries and potatoes ice cold. She said she has had to request her meals be warmed up because they were so cold when they were delivered, but the microwave in the activity area did not work very well. She said the cole slaw was too course of a texture for her taste. Resident #106 was interviewed on 4/21/21 at 5:08 p.m. He said he did not like the soup that was served on 4/21/21. He said he enjoyed the cole slaw and asked to have more but was told they did not have more available. Resident #106 was observed to eat all his canned peaches. He expressed he was still hungry and wanted more peaches, which was provided for him. (Cross-reference F692 Nutrition and F561 Choices) Resident #1 was interviewed a second time on 4/26/21 at 8:53 a.m. She said the prior weekend food was served cold. III. Resident council The March 2021 and April 2021 resident council minutes were reviewed. During the April 2021meeting, a resident requested eggs at breakfast. He said it would be ok if they were cooked with a liquid mix, as long as he received them. The April 2021 minutes revealed new menus would be available in May 2021. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2021 minutes identified food concerns. The following concerns were addressed in the meeting according to the minutes: -Cold food; -The gravy contained to much pepper; -Too many carrots were served According to the minutes, the dietary manager (DM) addressed the concerns. The minutes read the DM would review meal temperatures and inform the residents that they could request for their certified nurse aide (CNA) to warm the meal back up in the microwave. The DM would remove gravy off the meal tickets for residents that felt it contained too much pepper. IV. Test tray On 4/26/21 at 12:02 p.m., a test tray was covered with a plastic lid and placed on a tall metal cart with room trays prepared for residents on the 200 hall. The cart was not insulated or contained a heating element to maintain food temperatures. The cart was covered with a sheet and placed on the 200 hall for meal delivery. The test tray was evaluated immediately after the last room tray had been served to the residents in the 200 hall on 4/26/21 for lunch. -At 12:22 p.m. the regular diet test tray was evaluated by three surveyors. The test tray consisted of the main meal of sausage with peppers and onions, a dinner roll, and pan fried potatoes. The alternate meal test tray consisted of a sloppy [NAME] on a bun. A cup of chocolate ice cream was provided for dessert. There was not a vegetable served with the alternate meal. Temperatures of both meals were taken directly after the meal covers were removed. Temperatures read as following: Sloppy [NAME] was 110 degrees Fahrenheit (F); Sausage with peppers and onions were 105 degrees F; and The pan fried potatoes were 104 degrees F. -The following comments were made after test tasting both meals: there was a lack of vegetables served. Corn was on the menu but was not provided. The potatoes were cold, dry and bland in taste. The sausage with peppers and onion, and the sloppy joes were all lukewarm. The cool temperatures of both meals tampered with the overall taste of the food. V. Resident impression of the 4/26/21 meal A sample of 10 residents were interviewed during the 4/26/21 lunch. Comments were both positive and negative. Some of the residents did not express concerns, however the following comments were made by other residents: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The sausage was too spicy; -They were not offered a choice of ice cream flavor. The resident said she disliked chocolate; -The peppers and onions and potatoes were cold; and, -The sausage had a strange flavor to it. -At 12:34 p.m., a 300 hall resident was interviewed. She said she did not like the way the potatoes were prepared. She said the potatoes were dry and she was not offered ketchup to improve the dryness. She said the meal was not hot enough. -At 12:35 p.m., Resident #11 said she was not provided a vegetable with her sloppy [NAME]. She said she reviewed the menu and corn was supposed to be part of the meal. The resident said the corn would have been too high in starch after eating the sloppy [NAME] on a bun and would raise her blood sugar levels. The resident said she was diabetic. She said it was important to her to eat enough vegetables throughout the day so she requested a salad. The resident said she was disappointed with the salad. Resident #11 presented the salad and said she could not eat tomatoes but the only items in the salad was just lettuce and cheese. VI. Staff interviews Nurse aide (NA) #1 was interviewed on 4/26/21 at 10:14 a.m. She said food complaints would decrease if the kitchen provided more options and flexibility around resident preferences. She said Resident #106 would appreciate the option to have bacon daily. She said some residents become upset when they do not have options or received what they requested. NA #1 said Resident #24 preferred cranberry juice, orange and coffee. She said the resident would yell out when those preferences were not provided. CNA #3 was observed on the 400 hall serving room trays alone on 4/26/21 at 12:28 p.m. She said she had to heat all of Resident #11's meals in the microwave because she continued to express her dissatisfaction with cold meals. -At 12:37 p.m., CNA #3 said some residents complained about the food. She said they would tell her the food was not what they preferred or liked and would like more and different meal options. She said the residents used to have eggs to order but the kitchen no longer provided that option. She said Resident #51 used to eat breakfast well but since they stopped serving eggs like they used to, he did not eat a lot of breakfast. She said eggs were only available when it was scheduled on the menu. She said breakfast meat was also not a daily option for breakfast. The dietary manager was interviewed on 4/27/21 at 10:30 a.m. She said residents were tired of the menu. She said the facility would be switching to the new menus on 5/9/21. She said she had been asking residents for preferences/menu choices daily to try to identify ways to best accommodate. The DM said a microwave was available in the garden room if residents felt their meal was not warm enough. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dietary manager (DM) was interviewed a second time on 4/27/21 at 3:43 p.m. She said she was not aware the residents had expressed palatability concerns or taste. The DM said when she was informed of an individual resident concern she would try to accommodate the request such as offering a salad when a resident felt she did not receive enough vegetables with her sloppy [NAME] on 4/26/21. The DM said the sloppy [NAME] had diced peppers and onions already in the mix which could count as a vegetable serving. The DM said the registered dietitian was on vacation. The DM said she was only aware of complaints surrounding poor room tray temperatures. She said all meals were the appropriate temperature when the meals were plated and left the kitchen. She said she believed the meals lost temperature because the food carts were not adequately insulated to hold heat and CNAs did not serve the trays to the residents fast enough. She said if room tray delivery was quicker than residents would complain less about the food. She said staff could microwave the meals if the resident requested it. The DM said a quicker meal delivery was the only way she knew how staff could decrease the temperature complaints for the moment. She said the NHA was aware of the food temperature complaints for the past six months but has not purchased new delivery carts. The NHA was interviewed on 4/27/21 at 4:55 p.m. He said food was difficult to fully address. He said prior the new menu changes, meal satisfaction among residents received high scores. He said the current menus have created a decline in meal satisfaction. He said the facility was trying to make adjustments to the menu. The NHA said the facility was also focusing on room tray meal temperatures. He said the facility would be ordering new meal carts with covers for each hall to help maintain meal temperatures. The registered dietitian (RD) was interviewed by phone on 4/29/21 at 10:00 a.m. She said residents were getting tired of the current menu and they were implementing the new menu soon. She said food preferences should matter, the response to residents was very important, and they could find ways to brainstorm together to ensure residents were satisfied with the food. She said she had no advice for the facility other than to be creative. She said the resident council voted on a special meal each month. The RD said a new cycle of menus come out from corporate every season. She said the facility had the option to make menu substitutions based on resident response or resident council requests. The RD said a recent change to the menu based on resident requests was adding a vegetable medley as a side dish instead of carrots three times a week. The RD said she has heard multiple complaints regarding the menus and a diabetic diet. She said diabetic residents could have the same meal as the nondiabetic resident but with a smaller dessert. She said a diabetic resident could choose the alternate meal if they felt the main meal did not meet their diabetic needs. She said she hoped the kitchen could accommodate the concerned residents. The RD said she had no control over how the corporate dietitian created the menu. She said she personally felt the corporation needed to do a lot better about the diabetic diet. She said she would offer education to diabetics about balanced meals however, the RD said multiple residents who were not diabetic complained about how much starch was included in the daily menu. The RD said she would do her best to resolve the identified resident complaints. She said would review the temperature concerns with the dietary manager and investigate to identify the problem. She said residents could have extra salt or pepper available if they had concerns with meal flavor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VII. Record review The Menu at a Glance, weeks one, two and three, were reviewed for April 2021. The menu revealed the following: -Bread or a roll was frequently served together with potatoes or pasta, resulting in a high starch meal. -Peaches and pears were a routine breakfast item and as an occasional dessert -Bacon was offered twice as a breakfast item twice in a three week cycle. -Eggs were not a daily breakfast option but three to four days a week. -A vegetable side dish was on the menu every lunch and dinner; however based on test tray findings, vegetables may not always be served according to the menu. The Always Available menu was reviewed. The menu listed the following: Breakfast foods -Cinnamon rolls (available Tuesday, Thursday, Sunday) -Frosted Flakes (cereal) -Rice Krispies (cereal) Lunch/Dinner items -Baked chicken breast -Grilled cheese sandwich -Grilled ham and cheese sandwich -Hot dog -Peanut butter and jelly sandwich -Small salad (ranch or Italian) -Beef or chicken broth -Yogurt cup Regular and alternate menu -Fish (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Chicken breast -Grilled cheese -Grilled ham and cheese -Hot dog 12905 31797

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26246 Based on record review and staff interviews, the facility failed to collaborate with the hospice provider to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (#42) of one resident reviewed for hospice services out of 30 sample residents. Specifically, the facility failed to: -Develop a collaborative and integrative care plan; -Ensure documentation of Hospice nurse visits were available in the residents clinical record; and, -Ensure the Hospice agreement was current and up to date to include the current Clinical Executive Director (CED). Findings include: I. Hospice service agreement The Hospice Service Agreement, dated and signed by a previous nursing home administrator 4/15/10, was provided by the current NHA on 4/22/21 at 2:24 p.m. The agreement documented mutual duties as follows: Hospice and facility each shall maintain a copy of each patient's POC (plan of care) in the respective clinical records maintained by each party. Both parties shall maintain appropriate documentation of services provided under this agreement in accordance with applicable state and federal law and regulations. Patient medical records and documentation maintained by each party shall be available for review and inspection by the other party as necessary for the proper evaluation, screening, and provision of services to patients under this agreement . II. Facility policy The Hospice policy, revised 3/1/18, was provided by the NHA on 4/28/21 at 3:00 p.m. The policy documented in part, For patients nearing the end of life, (facility name) staff will offer the supportive services of a hospice program as requested by patients or their health care decision maker (HCDM), or as identified as a necessary resource by the interdisciplinary team (IDT). The Center will arrange for hospice services through contractual arrangements with a minimum of two local medicare certified hospice agencies to ensure that the patient/HCDM has a choice of hospices. The center executive director (CED) will ensure that: -Hospice services meet professional standards and principles that apply to individuals providing services in the center and to the timeliness of the services; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Center has a written agreement (contract) for each hospice that is signed by both an authorized representative of the hospice and the center before care is provided. A hospice agency contract may be used if it contains all of the elements identified in the policy; -Each patient ' s written plan of care includes both the most recent hospice plan of care and description of the services furnished by the center attain or maintain the patient ' s highest practicable physical, mental, and psychosocial well being. Process: Hospice ' s responsibilities for determining the appropriate hospice plan of care; Services the Center will continue to provide based on the patient ' s plan of care; Coordinating the Center ' s staff participation in the care planning process; and, Most recent hospice plan of care. III. Resident status Resident #42, [AGE] years of age, admitted on [DATE]. According to the April 2021 computerized physicians orders (CPO) diagnoses included Parkinson ' s disease, dementia, fracture of lumbar vertebra, multiple fractures of pelvis and anxiety disorder. According to the 3/29/21 minimum data set (MDS) assessment, the resident had moderate cognitive impairment. She had a brief interview for mental status (BIMS) score of nine out of 15. She was documented as receiving Hospice services while a resident in the facility. IV. Record review The 4/21 CPO documented orders for hospice services dated 3/22/21. The hospice face sheet dated 3/22/21 documented the resident ' s hospice diagnosis as Parkinson ' s disease. A comprehensive hospice admission progress note dated 3/22/21with hospice services and plan of care dated was found in the resident ' s clinical record under the miscellaneous tab. -There were no other hospice progress notes from visits found in the clinical record since 3/22/21. There was no comprehensive, collaborative hospice care plan found in the record either from hospice or the facility. V. Staff interviews (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospice nurse (RN) #3 was interviewed on 4/26/21 at 2:40 a.m. She said she was in the facility daily Monday through Friday. She said she had a system in place with the facility and met once a month to discuss residents. She said she saw Resident #42 once a week and the aides saw her twice a week. She said the hospice social worker and chaplain did their initial visit and would then determine visits as needed. She said she felt the coordination of care and communication with the facility was good. She said that she was currently visiting Resident #42 once a week. She said that the hospice documentation was done on her company computer tablet and then she would send her assessments to the facility electronically to be scanned into the resident ' s record under the miscellaneous tab. The NHA was interviewed on 4/27/21 at 9:00 a.m. He said the hospice contract he provided was the only one he had. He said they started working on creating a new contact just before COVID-19 hit and they had to put that on hold due to the COVID-19 pandemic taking precedence. The director of nursing (DON) was interviewed on 4/27/21 at 5:00 p.m. She said hospice would communicate with her and the floor nurse on duty when they visit. She said the social worker would be the one who normally coordinated care conferences, however; they were currently without a social worker. She said that the hospice and the facility coordinated each hospice resident plan of care to ensure continuity of care. She said there should be a hospice care plan by hospice and a hospice care plan that the facility created to ensure everyone was on the same page. She said the MDSC was responsible for creating the care plans. She said hospice should be sending their documentation and care plans to be placed in the resident ' s medical record after they complete each visit. She said that the medical records person would then upload the documents into the record under the miscellaneous tab. The MDS coordinator (MDSC) was interviewed on 4/27/21 at approximately 6:45 p.m. She said that she had been informed by the DON that Resident #42 did not have a hospice care plan in place (identified by the surveyor). She said she checked her record and saw that the hospice care plan had been resolved and no longer showing up in her care plans. She said she had one at one point but did not know why it had been removed. She said she would be initiating another hospice care plan today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26246 Based on observations, record review and staff interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections in three of four hallways Specifically, the facility failed to ensure: -Staff donned and doffed protective protection equipment (PPE) in the COVID-19 presumptive positive wing; -Staff properly performed hand hygiene when provide resident care; and, -Staff properly sanitized shared medical equipment between residents. Findings include: I. Facility policy and procedures The Infection Prevention and Control Program policy, revised 11/15/2020, was provided by the nursing home administrator (NHA) 4/22/21 at 2:25 p.m. The policy documented in part, The infection prevention and control program (IPCP) is a comprehensive process that addresses preventing, identifying, reporting, investigating and controlling of infections and communicable diseases for patients, staff, volunteers, visitors, and other individuals providing services under a contractual agreement. The policies and procedures are based on national standards (i.e., recommendations from the Centers for Disease Control and Prevention (CDC), the Association for Professionals in infection control and Epidemiology (APIC) and Society for Healthcare Epidemiology of America ([NAME]). Goals: The IPCP has been developed to provide staff with a coordinated organizational structure, technical procedures, comprehensive work practices, and guidelines to reduce the risk of transmission of infection or communicable diseases. The (IPCP) encompasses both employee health and patient care practices. The goals of the program are to: -Provide a safe, sanitary and comfortable environment; -Decrease the risk of infection to patients and staff; -Monitor for occurrence of infection and communicable disease and implement appropriate control measures; -Identify and correct problems relating to infection prevention and control practices; -Facilitate compliance with state and federal regulations relating to infection prevention and control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Hand Hygiene policy, revised 11/15/2020, was provided by the NHA 4/27/21 at 2:30 p.m. The policy documented in part, Adherence to hand hygiene practices is maintained by all Center personnel. This includes hand washing with soap and water when hands are visibly soiled and the use of alcohol based hand rubs (ABHR) for routine decontamination in clinical situations. To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Perform hand hygiene: before patient care, before an aseptic procedure, after any contact with blood or other body fluids, even if gloves are worn, after patient care and after contact with the patient ' s environment. The Cleaning and Disinfecting policy, revised 11/15/2020, was provided by the NHA 4/27/21 at 2:30 p.m. The policy documented in part: Cleaning and disinfection of patient care items and environment will be conducted based on risk of infection involved. To prevent infectious spread from items or environment to patients and/or staff. To ensure reusable medical equipment is cleaned and disinfected appropriately. -Multi-patient equipment must be cleaned/disinfected after patient use. II. Observations On 4/21/21 at 12:16 p.m., during lunch observations in the COVID-19 presumptive hallway, certified nurse aide (CNA) #2 was observed passing trays to four residents. She wore the same gown in and out of each of the resident rooms. She did not change her gloves in between serving the last two residents and, instead, sanitized her gloved hands with ABHR. On 4/21/21 from 2:23 p.m. to 2:40 p.m., nurse aide (NA) #3 was observed going in and out of three resident rooms with a rolling vital sign machine and checking vital signs. He did not sanitize his hands in between the residents and did not disinfect the vital sign equipment in between the residents. On 4/22/21 at 1:35 p.m. NA #3 exited a resident room with a mechanical lift. He rolled the lift down the hall and parked it at the other end of the building near the med room and left it there. He did not sanitize the lift with disinfectant wipes. On 4/22/21 at 4:05 p.m. licensed practical nurse (LPN) #1 washed his hand with soap and water in a quick manner for five seconds after administering medication. He then turned off the hot water handle with his bare hand instead of using a clean paper towel recontaminating his hands. On 4/26/21 at 3:24 p.m. to 3:30 p.m. CNA #12 was observed going in and out of two resident rooms and checking two residents ' vital signs. She did not sanitize the equipment in-between the two residents. She only sanitized her hands with ABHR in between residents. On 4/27/21 at 11:45 p.m. registered nurse (RN) #2 entered a resident room to perform a resident assessment. She turned on the hot and cold water faucet, rinsed her hands and applied soap and quickly rubbed her hands together and then rinsed her hands for a total of six seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III.Interview The director of nursing (DON) was interviewed on 4/27/21 at 5:00 p.m. She said that staff had to follow guidelines regarding PPE usage in the quarantine unit. She said there was signage posted to remind them what precautions they need to be taking. She said that PPE had to be changed in between resident rooms. She said ABHR should never be used on gloves and that gloves needed to be changed after each resident encounter. She said that staff should sanitize their hands with ABHR each time they go in to a resident room, after providing resident care and when exiting the room. She said hands should be washed for 20 seconds by turning on the water, applying soap to the hands and rubbing hands together, in between the fingers and then rinse in a downward motion. She said after drying hands, the faucet should be turned off with a clean paper towel. She said that medical equipment had to be disinfected in between each resident with the Micro-kill anti-bacterial wipes. She said after wiping down the equipment they should wait for two minutes before using it on someone else. IV. COVID-19 status The NHA reported upon entrance to the facility on [DATE] that they did not have any residents positive for COVID-19. They had four residents presumptive (new admissions), and one staff member that had tested positive.