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	07/28/2022

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 0600 Level of Harm - Minimal harm or potential for 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** 46851 Based on interviews, observations, and record review, the facility failed to take steps to protect one (#19) from resident to resident abuse out of 29 sample residents Specifically, the facility failed to ensure Resident #19 was free from physical abuse from Resident #43 that occured on 7/8/22. Findings include: I. Facility policy and procedure The Abuse policy and procedure, revised on 5/11/22, was provided by the nursing home administrator (NHA) on 7/27/22. It revealed in pertinent part: The center will implement an abuse prohibition program through the following: screening of potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation. Investigation of incidents and allegations, protection of patients during the investigation, and reporting of incidence, and investigations. And agency response to the results of their investigations. If the suspected abuse is patient to patient: The patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. The Central provides adequate supervision when the risk of patient-to-patient altercation is suspected. The center is responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The family and physician will be notified and any follow-up recommend it will be completed. Options for room changes will be provided based on the situation. The center should seek alternative placement for patients exhibiting the abuse of behavior if warranted. II. Incident of physical abuse between Resident #19 and Resident #43 on 7/8/22 On 7/8/22 Resident #19 was sitting in her wheelchair in the smoking area where she was the victim of unprovoked physical abuse perpetrated by Resident #43. Resident #43 grabbed and scratched Resident #19's arm, which was red and the scratches could be seen. Both residents were separated. The police were called. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 was interviewed on 7/8/22 she indicated there was no provocation and she was grabbed and scratched out of the blue. Resident #43 was interviewed on 7/8/22 in which she could not recall the altercation. The nursing home administrator (NHA) provided the investigation, which included the circumstances of the altercation (see above). The file also included one an interview from a certified nurse aide (CNA) and also the facility driver who observed the altercation, admission records, care plans, and medication administration records for both residents. The intervention added was to clip Resident #43's nails. -The facility investigation did not indicate whether or not the abuse was substantiated, however Resident #43 willfully grabbed and scratched Resident #19's arm. III. Residents A. Resident #43 1. Resident status Resident #43, age 86, was admitted on [DATE]. According to July 2022 computerized physician's orders (CPO), diagnoses include schizoaffective disorder and dementia without behavioral disturbances. The minimum data set (MDS) assessment dated [DATE], documented that the resident was unable to complete the brief interview for mental status (BIMS) with severely impaired cognition. The resident was rarely or never able to make herself understood or able to understand. The MDS indicated the resident had daily behavior problems such as hitting others. 2. Record review The behavioral care plan, dated 6/28/22, documented that Resident #43 has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Dementia (other than Alzheimer's disease), impaired decision making. Pertinent interventions included, to observe and evaluate types of changes in cognitive status, such as confusion, orientation, forgetfulness, decision-making ability, ability to express self, ability to understand others, impulsivity, mental status, and notifying the physician as needed. Observe for pain and effectiveness of current interventions. Attempt nonpharmacologic interventions. -Resident #43's behavior care plan was not updated after the 7/8/22 altercation. B. Resident #19 Resident #19, age under 65, was admitted on [DATE]. According to the 5/11/22 MDS assessment, her BIMS score is 13 out of 15. According to the MDS assessment, diagnosis includes debility and cardiorespiratory conditions. IV. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service director (SD) was interviewed on 7/28/22 at 1:02 p.m. She said she completed abuse investigations at the facility. She said there was an altercation between Resident #19 and Resident #43 on 7/8/22. She said the residents were separated, she notified the physician, the family, the police, and the power of attorneys. She said their intervention was to clip Resident #43's nails.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on observations, record review, and staff interviews, the facility failed to provide an ongoing program to support residents in their chosen activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three (#43, #28, #24) of five out of 29 sample residents. Specifically, the facility failed to offer and provide personalized activity programs for Resident #43, #28, and #24. Findings include: I. Facility policy and procedure The Recreation Services policies and procedure, revised 4/1/18, provided by the nursing home administrator (NHA) on 7/28/22. It was documented in the pertinent part, Residents have the right to participate or not participate in leisure and recreation of their choosing. The purpose is to provide leisure, recreation, and social involvement opportunities. Residents should be invited to participate in activities. Assistance will be offered to residents/patients who wish to participate but cannot get to activities independently. Residents who prefer not to participate in structured programs will be provided alternatives and necessary support/resources for meaningful individual pursuits of leisure interests. II. Resident #43 A. Resident status Resident #43, aged 86, was admitted on [DATE]. According to July 2022 computerized physician's orders (CPO), diagnoses included schizoaffective disorder and dementia without behavioral disturbances. The minimum data set (MDS) assessment dated [DATE], documented that the resident was unable to complete the brief interview for mental status (BIMS) with severely impaired cognition. The resident was rarely or never able to make herself understood. She required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. The resident had moderately impaired hearing and no hearing aides. She could not hear unless the volume was increased and the speaker spoke distinctly. The section on preferences for activities had not been completed. The MDS assessment dated [DATE], documented that the section on preferences for activities was completed by staff, not the resident or family. Staff indicated that it is important to the resident to have snacks between meals, listen to music, have access to animals, participate in group activities, spend time outdoors, and participate in religious activities. B. Resident observations 7/25/22 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:03 a.m., the resident was sitting in the wheelchair in her room and her television was turned off. -At 11:43 a.m., the resident was sitting in the wheelchair in her room and her television was turned off. The activities available to the resident per the activities calendar were one-on-one room visits and fresh air outdoors. 7/26/22 -At 12:59 p.m., the resident was sitting in the wheelchair in her room, turned away from her television and the television was muted. -At 1:58 p.m., the resident was sitting in the wheelchair in her room, turned away from her television and the television was muted. -At 3:13 p.m., the resident was sitting in the wheelchair in her room, turned away from her television and the television was muted. -At 3:23 p.m., the resident asked if she could get her nails done. -At 3:43 p.m., the resident was sitting in the wheelchair in her room, turned away from her television and the television was muted. -At 3:48 p.m., the resident was sitting in the wheelchair in her room, turned away from her television and the television was muted. -At 3:55 p.m., licensed practical nurse (LPN) #2 assisted the resident to the smoking area. The resident asked the activities director (AD) if she would do her nails; The AD said she would do them when the resident finished smoking. -At 4:30 p.m., the resident asked the AD to get her a Coke, the AD said that she would and left the resident in the hallway. After waiting a period of five minutes, the resident began to pull herself down the hall to her room using the hand railing. The AD did not return. 7/27/22 -At 8:07 a.m., the resident was still sleeping with her television on at a high volume. -At 8:24 a.m. LPN #2 entered the room but did not turn down the television. -At 9:47 a.m., the resident was sleeping with her television on at a high volume. -At 10:12 a.m., the resident was still sleeping with her television on at a high volume. -At 10:14 a.m., LPN #2 came in and woke up the resident to administer medications. -At 10:40 a.m., the resident was awake in her wheelchair in her room with a cup of coffee. She was yelling for the staff but no staff responded. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:03 a.m., certified nurse aide (CNA) #2 entered her room, changed and dressed the resident, then brought her to the foyer to wait to go outside and smoke. No one talked to her as she waited. -At 11:12 a.m., CNA #2 brought her outside to smoke. Her nails had still not been painted. C. Record review The activity assessment, dated 3/15/21, documented that it was important to the resident to have access to magazines, music, group activities, religious practices, animals, television, and going outside. She would like more salon activities. The comprehensive care plan, dated 6/28/22, documented in the activities section that the resident was dependent on staff to meet her emotional, intellectual, physical, spiritual, and social needs related to the disease process of dementia, immobility, and physical limitations. Staff were to ensure activities were being initiated and offered that met her preferences. Her preferences were to watch westerns on her television, watch videos on her IPad of dogs, be taken outside, receive communion, get her nails done and look at fashion magazines. The 7/1/22-7/28/22 activity participation record showed the resident participated every day in physical activities, movies, relaxing, looking out the window, and socializing. The record documented that the resident participated in an outside activity 21 out of the 28 days offered. D. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 7/28/22 at 9:00 a.m. She said that she often worked the hall where the resident resided but did not know what the resident liked to do and that she usually stayed in her room most of the day besides going out to smoke a cigarette Certified nurse aide (CNA) #2 was interviewed on 7/28/22 at 10:30 a.m. She said the resident's participation in activities depended on how she felt for the day. She said the resident spent the majority of her time in her room. The CNA said the resident liked to go outside to smoke and watch television. She needed assistance to get around in her wheelchair and showed a desire to roam around the building. The activities director (AD) was interviewed on 7/28/22 at 2:30 p.m. The AD said that the resident liked to spend time in her room. The activities she enjoyed were getting her nails done and looking through magazines. The AD also identified smoking and getting attention from staff as activities the resident enjoyed. She said that the resident's socialization needs were being met because the staff spends time with her. III. Resident #28 A. Resident status Resident #28, aged 70, was admitted on [DATE]. According to July 2022 computerized physician orders (CPO), diagnoses include Parkinson's disease, unspecified dementia with behavioral disturbances, progressive neurological conditions, and abnormalities of gait and mobility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/2/22 minimum data set (MDS) assessment showed the resident required one person extensive assistance with bed mobility, transfers, toileting, and personal hygiene. The section on cognition and preferences for activities was not completed by staff. The last MDS to include the residents' preferences for activities was 8/30/21. The source of information for the assessment was family or significant other, not the resident. It was documented that it was important to the resident to have access to the news, animals or pets, group activities, and family visits. It was also important to him to be able to go outdoors. B. Observation 7/26/22 -At 8:27 a.m, the resident was sitting in a wheelchair in his room without music or television on. -At 9:00 a.m., the resident remained in the same position with his television on but set to the home screen. -At 10:30 a.m., the resident remained in the same position without music or television on. -At 11:30 a.m., the resident remained in the same position without music or television on. -At 1:05 p.m., the resident remained in the same position without music or television on. -At 1:58 p.m., the resident remained in the same position without music or television on. 7/27/22 -At 8:46 a.m., CNA #5 brought the resident to his room after breakfast. The resident was left positioned in his wheelchair in the room without music or television on. -At 9:14 a.m., the resident remained in the same position without music or television on. -At 9:25 a.m., the resident remained in the same position without music or television on. -At 9:37 a.m., CNA#5 came into the resident's room and failed to offer him an activity. -At 9:42 a.m., the resident remained in the same position, the television was now on with volume low. -At 9:54 a.m., the resident remained in the same position, the television was now on with volume low. -At 10:04 a.m. CNA #5 came into the room to inform him that he would be taking a bath shortly but failed to offer him an activity. -At 10:06 a.m., LPN #2 went into his room to ask if he wanted to call his wife. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:11 a.m., LPN #2 returned with the phone. -At 10:16 a.m., CNA #5 said he was able to talk to his wife. The resident was observed continuously from 10:20 a.m. to 11:40 a.m. During continuous observation, the resident remained in the same position in his wheelchair in the room without music or television on. Throughout the observations from 8:30 a.m. to 11:40 a.m., no staff came into the resident's room to invite him to attend group activities or offer one-on-one visits from the activities staff. C. Record review The activity assessment, dated 8/30/21, documented that the resident indicated it was important to him to have access to books, newspapers, magazines, animal visits, television to watch or listen to, music, group activities, and the outside. The comprehensive care plan, dated 3/16/22, documented in the activities section that the resident was dependent on staff to meet his emotional, intellectual, physical, spiritual, and social needs related to the disease process of dementia. His preferences were to play cards, share stories and reminisce, look at his books, watch his favorite programs, spend time with family, and receive one on one visits from activities staff one to two times a week. D. Staff interviews CNA #7 was interviewed on 7/28/22 at 9:00 a.m. She said that the resident sits in his room watching television and eating snacks. He required staff assistance to attend group activities or independent activities in his room. CNA #2 was interviewed on 7/28/22 at 10:30 a.m. She said the resident usually has visitors and they bring him snacks and play games with him. The activity director (AD) was interviewed on 7/28/22 at 2:30 p.m. She said that the resident liked to spend time visiting with staff and having one-on-one time with them. He ate in the dining room and because staff spends time with him, his socialization needs were being met. The director of nursing (DON) was interviewed on 7/28/22 at 4:09 p.m. She said that activities were offered to residents throughout the day by staff. IV. Resident #24 A. Resident status Resident #24, aged 89, was admitted on [DATE]. According to July 2022, CPO diagnoses include dysphasia (swallowing difficulty) and cognitive-communication deficits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/17/22 MDS assessment showed the resident was cognitively intact with a score of 14 out of 15 for the BIMS. The resident required one-person assistance with supervision, oversight, encouragement, and cueing for bed mobility, transfers, bathing, and toileting. The resident had limitations to his range of motion on both sides of his upper and lower extremities. He used a wheelchair for mobility. It was documented that it was important to the resident to attend religious services, have access to the news, animal visits, and go outdoors. B. Resident interview The resident was interviewed on 7/26/22 at 9:27 a.m. The resident stated that he did not have enough to do. He spent his day in his room watching television. He said he was not assisted outside by the staff and he had always enjoyed being outside and doing outdoor activities. The only time he was assisted outside was when his grandson came to visit him. C. Observations Throughout the survey from 7/25/22 through 7/28/22, the resident was observed sitting in his wheelchair in his room. The television was on, but the resident was not assisted outdoors. D. Record review The activities assessment dated [DATE] documented that the resident enjoyed the outdoors, birdwatching, and observing wildlife. The activity participation records for June 2022 and July 2022 failed to show the resident was assisted outdoors by staff. The activity director (AD provided a July 2022 activities calendar on 7/28/22 at 2:30 p.m. It showed that fresh air outdoor activity was offered once a day. The comprehensive care plan revised on 5/16/22 identified that it was important for the resident to go outside. The pertinent intervention was to ensure the resident was encouraged to participate in activities he enjoyed. E. Staff interview The activity director (AD) was interviewed on 7/28/22 at 2:30 p.m. The AD confirmed the resident spent the majority of his day in his room and he liked to go outdoors. She was not able to say how often he was assisted outside by staff. 20287

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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** 40467 Based on observations, record review, interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for two (#8 and #51) of two residents out of 29 sample residents. Specifically, the facility failed to: -Ensure the Resident #8's edema was routinely monitored and documented; -Ensure Resident #8 had interventions in place and timely to prevent the worsening of edema; -Ensure Resident #8 had opportunities and assistance to elevate her legs to prevent the worsening of the edema that were based on her preferences of daily routine; and, -Ensure physician's orders were followed for Tylenol administration for Reident #51. Findings include: I. Facility policy The Skin/Wound Management policy, undated, was provided by the nursing home administrator (NHA) on 7/28/22. The policy identified staff should provide weekly skin/wound status updates to the Interdisciplinary team members including therapists and dieticians. They should notify skin ruin status updates to healthcare decision makers including providing appropriate education requiring resident risk factors wound status wound goals and resident goals. Staff should notify the provider and obtain orders as indicated. And notify the director of nursing (DON) and the NHA of any deviation from guidelines requested by the physician/provider. According to the policy, staff should monitor all dressings and wounds daily to include: -The status of the dressing including if the dressing was intact and not leaking. -The status of the tissue surrounding the dressing such as no new redness or swelling. -If there was the presence of wound pain. II. Resident #8 A. Resident status Resident #8, age 77, was admitted on [DATE] and readmitted on [DATE]. According to the July 2022 computerized physician orders (CPO) diagnoses included type two diabetes mellitus with diabetic chronic kidney disease, pulmonary hypertension due to lung disease and hypoxia, heart failure, difficulty walking, reduced mobility, and morbid obesity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/19/22 minimal data set assessment (MDS) identified the resident required extensive assistance from more than two persons for bed mobility. She needed extensive assistance from one person for transfers, dressing, toileting and personal hygiene. The brief interview for mental status (BIMS), last completed during the 2/21/22 MDS assessment, indicated the resident had moderate cognitive impairment with a BIMs score of 12 out of 15. B. Resident observation and interview Resident #8 was interviewed on 7/25/22 at 11:12 a.m. She said her feet were hurting her. The resident sat in a wheelchair in her room. Her feet rested directly on the floor. The resident did not have foot pedals. She had wraps loosely hanging off her legs, exposing her very edematous (swollen) and red feet. Resident #8 said she was supposed to elevate her legs but her lounge chair was broken and the foot lift no longer supported her feet when she sat in it. Observations of the room did not identify supportive devices to elevate her legs. The resident did not have a bed located on her side of the room. She said she used the lounge chair as a bed because it was uncomfortable for her to lay flat in bed. She said she would rest her legs on her wheelchair when she slept in her lounge chair. She said did not want to spend all day in her broken lounge chair so she would only use it to sleep. The resident said the foot stand to the lounge had not worked for the past few weeks and was told they are waiting on a part. She said besides resting her feet on her wheelchair at night, she did not have any other way to elevate her legs. She said staff had not been offered any other means, such as a stool, to elevate her legs. Resident #8 said the swelling and pain have increased. Resident #8 was interviewed on 7/26/22 at 4:56 p.m. Observations through the afternoon of 7/26/22 identified the resident sat in her wheelchair with her feet directly on the ground. Her feet were completely wrapped from calves to her toes.The resident said she had not elevated her legs on 7/26/22 since she got up for the day. She said staff has not offered or encouraged her to elevate her legs as she sat in her wheelchair for the day. Additional observations identified Resident #8 routinely did not have her legs elevated during the day. On 7/27/22 between 8:51 a.m. and 9:16 a.m. the resident ate breakfast in her room with her feet resting on the floor. -At 10:17 a.m. Resident #8 remained in her room in her wheelchair. Her left foot was partially unwrapped and approximately a foot in length of her dressing was on the floor. -At 12:20 p.m. her legs were wrapped. Resident #8 said her feet were really hurting this morning. She said her feet feel better when they are tightly wrapped and not wet. She said her wraps often come undone at night and then continue to unravel in the morning until the nurse rewrapped them. Her feet remained on the floor not elevated. -At 2:01 p.m. the resident's legs were wrapped but not elevated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 2:55 p.m. Resident #8 was in her wheelchair in her room. Her feet were on elevated foot rests fastened to her wheelchair. She said the facility just put them on and said her feet felt better elevated. She would do anything not to have them not hurt. She said she was concerned if she would be able to propel her wheelchair with just the use of her arms. She said she usually would use her feet to move her wheelchair. She said she would talk to the nurse about it. On 7/28/22 at 8:39 a.m. a bed was added to her room. She said she tried it last night but she could not sleep well. She said she talked with her roommate and the roommate will let borrow her lounge chair until Resident #8's lounge chair was fixed. C. Record review The clinical management care plan, last revised 2/12/21, read the resident's weight was expected to fluctuate due to edema and diuresis (increased urine production). The edema care plan, last revised 3/4/21, read Resident #8 was at risk for or exhibited fluid volume excess in her bilateral lower extremities. According to the care plan, the resident needed to have her legs elevated as tolerated when sitting. -The care plan did not identify any new interventions since 3/4/21. The skin integrity care plan, last revised 11/17/21, directed staff to elevate the resident's legs. The care plan read the resident requested to have her bed removed from her because of her chronic obstructive pulmonary disease (COPD) with shortness of breath. The care plan read the resident preferred to sleep and sit in her care plan. The care plan read bilateral lower extremities but the care plan did not identify how her bilateral lower extremities related to the care plan. According to the care plan, the resident's reclining lounge chair broke 11/12/21 and she had a bed. -However according to staff interview (see below) and Resident #8's interview, the chair broke in June 2022. The care plan did not identify if the resident's chair broke in November 2021, was fixed, and broke again in June 2022. The care plan did not identify the resident had edema. The 12/8/21 CPO directed staff to measure Resident #8's bilateral lower extremities (BLE) and contact the lymphedema clinic for recommendations on treatment options and call the physician with the recommendations. The 3/4/21 CPO read for Resident #8 to have her wheelchair cushion beneath heels to promote increased elevation secondary to edema management. The orders were directed to ensure placement twice a day. The weight record for Resident #8 identified she had an increase of 12.2 lbs pounds between 6/1/22 and 7/21/22 (last weight recorded). The skin check assessments between 6/2/22 and 7/21/22 read Resident #8 had a Braden score of 15 indicating the resident had a mild risk for skin breakdown related to incontinence, injections, decreased activity, eczema, frail and fragile skin. The skin checks did not identify the resident had edema. The skin checks read the resident had a skin injury. The skin check identified the resident had a small opening identified on her buttocks. According the skin checks, staff should: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe skin for signs/symptoms of skin breakdown such as redness, cracking, blistering, decreased sensations and not blanched skin. -Evaluate for any localized skin problems such as redness, pustules, and inflammation. -Observe skin conditions daily with activities of daily living (ADLs) and report abnormalities. -Off load/float while in recliner with wheelchair cushion as tolerated. -Obtain skilled physical therapy/occupational therapy evaluation to improve function and mobility. -Provide pressure redistribution surface to her chair per therapy recommendation. -Obtain a dietitian's consultation as needed or ordered. -Provide preventive skin care as ordered. -The skin checks between 6/2/22 and 7/21/22 did not change interventions, identify edema, or identify the pitting measurements of the edema. The skin checks remained the same week after week. A 6/3/22 maintenance request was provided by the maintenance service director (MSD) on 7/27/22 at 12:26 p.m. According to the 6/3/22 work order, Resident #8's chair was not working and the technician was coming on 6/4/22. A second maintenance request follow up, undated, was provided by the maintenance service director (MSD) on 7/27/22 at 12:26 p.m. The request follow up read the retail store technician looked at the chair on 6/4/22. On 7/7/22 the chair parts arrived at another store. The parts would arrive in two to four weeks and would contact the facility when the parts were available. The 7/13/22 physician note indicated Resident #8 weight increase and an increase in lower extremity edema. The note read the resident had increased fluid in her legs and reported leaking for several weeks. The July 2022 treatment administration record (TAR) record read the resident staff placed a wheelchair cushion under the resident's heels with the resident in her recliner every day twice a day except the night of 7/8/22 and the morning of 7/14/22. The 7/20/22 CPO directed staff to administer Bumex tablet (diuretic) at two milligrams (mg) by mouth twice daily for chronic heart failure (CHF). The 7/21/22 quarterly review nursing note read the resident occasionally complained of pain related bilateral leg swelling. According to the note, the resident was educated on the importance of elevating due to the swelling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/21/22 general note read the nurse removed the resident's dressing from her bilateral lower extremities. Resident #8 had 4 out of 4 pitting edema. According to the note, there was a large amount of drainage coming from both legs. The were blisters present with green colored pus draining out of the blisters. Her lower extremities were cleansed with soap, water and a wound cleaner. The note identified ABD (highly absorbing dressing) pads were applied to the weeping areas of the legs, wrapped with ace wraps and covered with TED (thigh anti-embolism) stockings. The note indicated the physician was notified. The 7/27/22 CPO directed staff to cleanse the resident skin with soap water and washcloth pat dry and then cleanse with a wound cleaner. Apply gentamicin to a non adherent pad, and place side to the wounds with the pad. Wrap tubi grip size G over abdominal pad and kerlix. Change the dressing on Tuesday, Thursday and Saturday and as needed every 12 hours. -The CPO did not identify where the wounds were identified and needed to be treated. The 7/28/22 general note read Resident #8 was encouraged to utilize a bed due her huge edema." The resident agreed to use the bed. According to the note, staff would continue to encourage her to elevate her legs which might help to decrease the edema. D. Staff interview The maintenance service director (MSD) was on 7/27/22 at 12:14 p.m. He was informed in June 2022, Resident #8's personal lounge chair was not working. The retail outlet she ordered from was contacted and a technician was sent out. The technician identified the chair needed replacement parts to fix. The parts have been on order and trying to work out funding with the business office and family. The rehab service director (RSD) was interviewed on 7/28/22 at 10:32 a.m.The RSD said Resident #8 was not currently on therapy/rehab services nor were services requested by the physician or nursing to have therapy suggest potential solutions to help the resident elevate her edematous legs. The RSD said it was very important to elevate legs to reduce edema. She said if Resident #8's legs were not elevated, it could worsen the edema. She said staff have not requested therapy/rehab services to evaluate her since April 2022. The RSD said the resident had gone to an edema clinic. The RSD said Resident #8 could be a good candidate for therapy for wheelchair mobility while she used her foot pedals. The RSD said therapy could also look at her pain related to her edema. She said she would set up a therapy evaluation for Resident #8. Licensed practical nurse (LPN) #3 was interviewed on 7/27/22 at 2:10 p.m. The LPN #3 said she has been Resident #8's nurse for the past month. She said the resident did not like to elevate her legs in her reclining lounge chair during the day but had not documented the refusals. She said she was aware that the lounge chair leg rest was broken. She said recently she had trying to problem solve how to elevate Resident #8's legs with the resident's other nurse, registered nurse (RN) #1. She said they were still in the brainstorming phase of finding a solution. She said they have not thought about involving therapy on possible ways to elevate the resident's legs during the day. She said if the resident wanted to recline in her chair with her feet up, they could place a wheelchair under the chair's foot rest. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed and on 7/27/22 at 3:01 p.m. She said they have fastened foot pedals to the resident's wheelchair to help elevate her legs a little. She said she would ask therapy to evaluate her if her foot rests impact the resident's mobility. The LPN said she has been concerned about the significant swelling of Resident #8's feet. She said Resident #8's edema had been bad. She said her toes looked like they would pop right off. Unit manager (UM) #1 was interviewed on 7/27/22 at 5:01 p.m. The UM said on 7/27/22 the physician put new orders on the CPO to elevate her legs and chart refusals. Staff would continue to look at her medication, lab work and kidney function. The UM said nursing also needed to get a new weight for Resident #8. She said she would educate the nursing staff to encourage and assist the resident with elevating her legs and chart refusals. UN #1 said the nursing staff should chart when and why the resident refused to elevate her legs so they could identify a pattern and notify the physician. She said there was always a reason why someone would refuse an order, they needed to find out. She said staff needed to offer to assist the resident out of her wheelchair and foot elevation options. The registered dietitian (RD) was interviewed on 7/28/22 at 2:24 p.m. She said increased edema would increase the resident's weight related to a fluid increase. She said she was not aware of the resident's current edema. She said she would look at the resident's salt intake. She said the resident was already on a controlled carbohydrate (CCHO) diet. UM #1 was interviewed on 7/27/22 at 5:25 p.m. She said staff placed a bed in the resident's room on 7/27/22. She said the resident agreed to use it to help elevate her legs. The NHA and the director of nursing (DON) were interviewed on 7/28/22 at 7:20 p.m. They said they were not aware the resident's reclining wheelchair was broken or her increased edema. The NHA said she would work on creating an ottoman so the resident could put her feet up during the day when she was in her wheelchair. She said she would also reach out to the corporate office to help buy the resident another chair if that was necessary. The NHA said if staff would have communicated the concern with her sooner, she would have taken action sooner. She said the facility was in a transition related to new nursing management. She said she needed to work with staff to improve communication and monitoring. She said staff need to also chart refusals so they can get to the root cause of the problem and set up a new care planned intervention. The NHA, also a RN, said edema could be related to cardiac issues and could cause breathing problems, heart problems, and skin pain. 42193 III. Resident #51 A. Resident status Resident #51, age 86, admitted on [DATE]. According to the July 2022 computerized physician orders, diagnoses included, of unspecified chronic pain, restless leg syndrome, Alzheimer's disease, and anxiety disorder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/23/22 minimum data set (MDS) assessment included the resident having no cognitive impairment with a brief interview for mental status of 15 out of 15. The resident required supervision with toileting, dressing or personal hygiene, the pain assessment interview in MDS indicated the resident experienced pain on a daily basis. The number the resident referred to on the pain scale was 3 which was a tolerable level for Resident #51 which indicates mild pain. B. Resident interview Resident #51 was interviewed on 7/25/22 at 9:30 a.m. She said she had pain in her left arm all of the time. She said the pain medication worked well only part of the time. Resident # 51 was interviewed again on 7/28/22 1:40 p.m. She said she was on hospice care and received Morphine sulfate solution at 7.5 milligrams three times a day. She said it helped pretty well with pain but sometimes she needed Tylenol as well to supplement the Morphine. C. Record review Pain measurement on the pain scale for mild pain was between 1-3, moderate pain was between 4-6 and severe was between 7-10. The resident was admitted to hospice on 6/22/22. The July 2022 CPO showed an order which read, Tylenol 325 mg tab, give 2 tabs every 4 hours as needed for mild pain. The medication administration record (MAR) for July 2022 showed that Resident #51 experienced moderate pain (over four on the pain scale) on 16 days of that month. According to the MAR, the resident was experiencing moderate to severe pain and she was administered the dose of Tylenol that was intended for mild pain. D. Interviews Licensed practical nurse (LPN) #4 was interviewed on 7/28/22 at 1:50 p.m. LPN #4 said Resident # 51 usually experienced moderate or severe pain. He said the resident was prescribed a morphine sulfate solution 7.5 milligrams dose three times a day for pain. He said if the resident was still in pain an hour later, he would administer the PRN (as needed) Tylenol dose. The director of nursing (DON) on 7/28/22 at 3:16 p.m. She said the Tylenol order on the July 2022 MAR was incorrect because the resident had moderate pain most of the time and the order indicated a dose for mild pain.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40840 Based on record review, interviews and observations the facility failed to ensure proper monitoring and assessments of pressure injuries for three (#56, #18, and #24) of five residents reviewed for pressure injuries of 29 sample residents. Specifically, the facility failed to continuously monitor and assess wound measurements for residents. Findings include: I. Professional reference The NPUAP Pressure Injury Stages,The National Pressure Ulcer Advisory Panel, was retrieved on 8/2/22 at http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages read in pertinent part: 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. -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. II. Facility policy and procedure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Skin Integrity Management policy, revised 6/1/21, provided by the nursing home administrator (NHA) on 7/28/22 at 10:30 a.m. read in pertinent part the implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observe and monitor patients for change and implement revision to the plan of care as needed. Practice standards included performing wound observations and measurements and complete skin integrity report upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. III. Resident #56 A. Resident status Resident #56, age 81, was admitted on [DATE]. The July 2022 computerized physician orders (CPO) included diagnoses of multiple sclerosis, contracture of muscle in multiple sites, and pressure ulcer of right buttock stage 2. According to the 6/24/22 minimum data set (MDS) the resident scored a 14 out of 15 on the brief interview for mental status (BIMS) assessment indicating the resident was cognitively intact. The MDS did not indicate the resident had any pressure related injuries. III. Record review A. Progress notes According to the July 2022 computerized physician orders (CPO) the resident was diagnosed with a stage 2 pressure injury acquired during her stay in the facility onset of 11/22/21. A nursing progress note on 11/22/21 at 12:41 a.m. identified the first documentation of treatment for the wound showing the wound was cleansed and patted dry before calcium alginate was packed into the wound and dressed with a mepilex dressing. The primary care provider (PCP) was noted to be notified. There were no measurements given. Treatment administration records (TARs) provided by the facility for the resident showed wound care treatments for the pressure injury initially began on 11/22/21. B. Skin integrity reports Skin integrity report were provided by the facility, these reports included an assessment of the wound measurements, drainage, wound edges, undermining, tunneling, wound related pain, odor and appearance The first skin integrity assessment was dated on 11/29/21(seven days after initial identification). It was noted the wound was in-house acquired. Skin integrity reports continued to show the wound was assessed weekly through the month of December 2021. Skin integrity reports for January 2022 were documented for 1/3/22, 1/10/22, and 1/17/22. -There were no other skin reports for the month of January 2022 or documentation of wound assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The skin integrity reports were noted for February 2022 on 2/10/22 (three weeks since last assessment), 2/14/22, and 2/21/22. The skin integrity reports were noted for March 2022 on 3/1/22, 3/9/22, and 3/28/22 (19 days later). The skin integrity reports for March were noted on 4/4/22, 4/12/22, and 4/18/22. -There were no further skin integrity reports documented for the resident. The next documentation showing the wound assessment was on 7/25/22 at 3:37 p.m. in a nursing progress note which noted the measurements of the wound (no significant changes from previous measurements), and no signs or symptoms of infection. It was noted the wound appeared to be healing and the resident denied any pain. IV. Resident #18 A. Resident status Resident #18, age 69, was admitted initially on 1/29/22, and readmitted on [DATE]. The July 2022 CPO diagnoses included necrotizing fasciitis (bacterial infection of the skin), end stage renal disease, type two diabetes mellitus, and pressure ulcer of sacral region present on admission. According to the 3/10/22 minimum data set the resident scored a 15 out of 15 on the brief interview for mental status (BIMS) assessment indicating the resident was cognitively intact. According to the MDS the resident was being treated for a pressure injury stage 1 or higher. A. Progress notes A wound nurse consultation from the hospital on 1/24/22 showed the resident was being treated and would be discharged with an unstageable pressure injury to her coccyx. The resident's facesheet provided by the facility showed the resident was admitted with an unstageable pressure injury on 1/29/22. B. Skin integrity reports Skin integrity report were provided by the facility, these reports included an assessment of the wound measurements, drainage, wound edges, undermining, tunneling, wound related pain, odor and appearance The initial skin integrity report after admission was documented on 1/31/22 with full measurements (two days after admission). Weekly skin integrity reports were provided for February 2022 on 2/9/22, 2/11/22, 2/15/22, 2/18/22, and 2/21/22 (it was noted the resident had gone to the hospital at some point after the 2/21/22 assessment for a reason other than the wound and readmitted on [DATE]). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2022 skin integrity reports were only documented for the resident on 3/7/22 and 3/29/22. The April 2022 skin integrity reports were documented on 4/1/22, 4/12/22, and 4/19/22. The 4/19/22 report was the last documented assessment. There were no further measurements noted in the electronic medical record (EMR) for the resident's wounds until a wound management tracking tool dated 7/27/22 provided by the facility on paper showed the measurements significantly improved since the last measurement (4/19/22) and healing. V. Resident #24 A. Resident status Resident #24, age 89, was admitted on [DATE]. According to the July 2022 CPO diagnoses included, dysphasia (swallowing difficulty), multiple myeloma (cancer), and cognitive communication deficits. The 5/17/22 MDS assessment showed the resident was cognitively intact with a score of 14 out of 15 for the brief interview for mental status (BIMS). The resident required supervision with activities of daily living. The MDS coded the resident as having an unhealed stage 2 pressure injury. B. Record review The July 2022 CPO showed a physician order to cleanse buttocks with wound cleanser and pat dry. Place Medpliex to the right inner buttock wound, skin prep to surrounding area. Check placement every day and change on bath days and PRN (as needed) Review of the skin assessment dated [DATE] showed the resident had a skin impairment. -However, the document did not indicate the stage of the pressure injury, or the measurements. The 3/4/22 skin integrity report from the wound physician documented a stage 2 pressure injury and was 0. 75 centimeters (cm) x 0.75 cm x 0.2 cm in size. -The medical record did not have any further documentation in regards to the measurements, or the progress of the wound. C. Observation On 7/26/22 at 3:04 p.m., the resident was observed to receive the dressing change. The pressure injury was scabbed over. The Medpliex was placed over the scab with no obvious signs or symptoms of infection. The resident did not complain of pain with care. D. Interviews The resident was interviewed on 7/26/22 at 9:38 a.m. The resident said he had a pressure ulcer on his buttocks. He said that the nurses put a patch on it. He said it did not hurt. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #2 was interviewed on 7/28/22 at 12:16 p.m. LPN #2 said the stage 2 pressure ulcer was healed, and it was scabbed over. She said the staff place the patch over it to protect it. She said no one kept track of the measurements of the wound. She said staff would only track measurements when it was open. VI. Weekly skin reports Weekly skin reports were provided by the facility. They did not include continuous assessments of current wounds with measurements for residents. VII Staff interviews Unit manager (UM) #2 was interviewed on 7/27/22 at 10:30 a.m. She said she was taking over the wound care since the previous wound care nurse quit at some point in April 2022, but she had only been working at the facility for two weeks. She was unsure where or if documentation for wounds was being monitored during that time in between. Licensed practical nurse (LPN) #2 was interviewed on 7/27/22 at 3:40 p.m. She said they had a wound nurse that was completing the weekly measurements and assessments of wounds but she had left. She said the floor nurses would do it only if they saw a drastic change in the wound otherwise they would just document they did the wound care and the weekly skin assessments which did not include the measurements. The NHA, a registered nurse, and the director of nursing (DON) were interviewed on 7/28/22 at 6:18 p.m. The NHA said the process for the nurses were to do weekly skin assessments, but the skin assessments did not include the assessment for infection or measurements of wounds. She said the previous wound nurse had left employment with the facility so the nurses were supposed to take over the responsibility for wound assessments and measurements until recently when the UM #2 took it over. She said the corporate owner of the facility has identified issues with wound care and they had a team coming in to train their nurses via a corporate program on wound care which would qualify her staff to sit for wound care certification. 20287

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42193 Based on record review and interviews, the facility failed to ensure two (#51 and #36) of seven residents with limited range of motion received appropriate treatment and services out of 29 sample residents. Specifically, the facility failed to establish a consistent restorative nursing program within the facility to ensure Resident #51 and #36 did not have a potential decline in activities of daily living (ADL). Findings include: I. Resident #51 A. Resident status Resident #51, age 86, admitted on [DATE]. The July 2022 computerized physician orders indicated a diagnosis of unspecified chronic pain, colostomy status, restless leg syndrome, Alzheimer's disease, anxiety disorder, and dysphagia (swallowing difficulty). The 6/23/22 minimum data set (MDS) assessment included the resident having no cognitive impairment with a brief interview for mental status of 15 out of 15. The resident required supervision with toileting, dressing or personal hygiene, and one person assistance with bathing. The resident had functional limitations in range of motion with impairment on one side. The MDS indicated that the resident was not involved in any kind of restorative or rehabilitative therapy. B. Record review The care plan for Resident #51, dated 7/7/22, documented the resident required assistance/was dependent for ADL care in bathing, locomotion, toileting related to: limited mobility. Resident #51 would maintain highest capable level of ADL ability throughout the next review period as evidenced by his/her ability to perform:locomotion/ambulation. -There was no restorative program or care plan indicated in the resident's medical chart. II. Resident #36 A. Resident status Resident #36, age 65, was admitted on [DATE]. The July 2022 computerized physicians orders indicated a diagnosis of chronic pain syndrome, cerebral infarction (stroke) and contracture of left arm. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/10/22 minimum data set (MDS) assessment included the resident was cognitively intact for a brief interview of mental status (BIMS) of 15 out of 15. The resident required limited assistance with bed mobility, transfers, extensive assistance with toilet use, dressing and bathing. The resident had functional limitations in range of motion on one side. The MDS indicated the resident was not involved in any kind of restorative therapy. B. Record review The care plan for Resident #36, dated 3/24/22, indicated the resident was at risk for alteration functional mobility related to a decrease in range of motion, left hemiplegia. The resident has a contracture of her left leg related to non use. The goal for the resident is the resident will have no increase in contractures in the next 90 days. Intervention included to provide adaptive equipment for activities of daily living (ADLs) as indicated with the knee and wrist brace program. -There was no restorative program or care plan indicated in the resident's medical chart. III. Interviews Certified nurse aide (CNA #1) was interviewed on 7/28/22 at 9:47 a.m. She said there was no restorative program in place however she did help Resident #51 with a range of motion exercises every morning. She said registered nurse (RN) #3 asked the CNAs to assist the residents with a range of motion exercises. She said there was no record of the range of motion exercises in the charts. The director of nursing (DON) was interviewed on 7/28/22 at 2:56 p.m. She said the facility did not have a restorative CNA or nursing program for the residents. RN #3 was interviewed on 7/28/22 at 5:06 p.m. She said the facility did not have a restorative program and had not for a while. She said Resident #36 had left side affected due to a stroke and was not receiving treatments for this. The DON and nursing home administrator (NHA) were interviewed on 7/28/22 at 6:00 p.m. The NHA said the facility did not have a restorative program but the CNAs should be doing a range of motion exercises with the residents regardless. The DON said the facility will be implementing a restorative program for the residents very soon.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to ensure the facility provided adequate supervision and monitoring for two (#16 and #316) residents out of three residents reviewed for falls and accidents out of 29 sample residents. Systematic facility failures were identified for Resident #16 and Resident #316. The failures resulted in repeat falls resulting in injury and pain. Resident #16 had a history of falls with injury. On 7/14/22 staff identified the resident had a four inch long, deep purple bruise on his left arm. His left arm was swollen and he expressed a worsening of pain. Documentation identified the resident requested to have an x-ray to his arm. The resident did not have the x-ray until 7/26/22, 12 days after his request. The 7/26/22 x-ray determined Resident #16 had a fracture to his left shoulder. The facility did not identify how the resident acquired the injuries. The facility did not conduct a fall investigation on or after 7/14/22. The facility did not conduct a bruise of unknown origin investigation. The resident's nursing staff said the bruising and swelling was due to a possible blood clot, or a residual injury from a fall on 6/12/22. The staff confirmed the injuries were not observed prior to 7/14/22 and the resident had x-rays after the 6/12/22 fall. The physician assessed the resident on 7/14/22 and felt the resident had a possible rotator cuff injury. The physician was informed by the unit manager, Resident #16 was in horrible pain. On 7/15/22, the physician prescribed pain medication and physical therapy. The physician did not provide orders for an x-ray on 7/15/22. The resident was evaluated for physical therapy on 7/19/22, fours days after the order, for transfer training and left shoulder pain. During physical therapy on 7/20/22, the resident expressed he was in pain and refused to have his left arm moved, stating it's broken. The physician provided an order for the x-ray on 7/20/22 but did not receive x-rays until 7/26/22, six days after the order. Additional facility failures for Resident #16 included lack of new fall interventions implemented and care planned after the resident fell on [DATE] and the probable fall on 7/14/22, to prevent the recurrence of future falls. Resident #16 suffered pain and delay in treatment. The facility delayed the resident's treatment when he did not have an x-ray to rule out a significant injury for over two weeks after the resident's request. The x-rays determined there was a significant injury and the resident was provided a sling for arm and shoulder support. The resident also had a delay in treatment after the resident fell on [DATE]. The resident was not provided orders to have therapy services after the 6/12/22 fall. Resident #316 was newly admitted with severe dementia, poor safety awareness and unsteadiness. The facility failed to identify, assess and implement interventions to prevent falls with injury. These failures contributed to the resident experiencing a fall on her first night in the facility, and a total of six falls within three weeks. As a result, the resident suffered large hematomas to her face and right hip, a head injury, severe pain, and two emergency room visits for treatment after falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy The Fall Management policy, last reviewed on 6/15/22 , was provided by the nursing home administrator on 8/3/22 via email. The policy read in pertinent part: Interventions to reduce the risk and minimize injury would be implemented as appropriate .Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented. According to the policy, the purpose was to: -Identify risk for falls and minimize the risk of recurrence of falls. -Evaluate the patient for injury post-fall and provide appropriate and timely care. -Ensure the patient-centered care plan is reviewed and revised according to the resident's fall risk status. The steps for post fall management were outlined in the policy. The policy identified: -If a fall occurred, an assessment will be completed to determine possible injury. -Notify the physician of the fall, report findings and the extent of injury, and obtain orders if indicated. -If the injury is of an emergent nature, the resident will be transported to the hospital. -If the extent of the injuries can not be determined, the nurse will notify emergency medical services (EMS) for evaluation and transport to the hospital. -Any resident who sustained an injury to the head from a fall and or had a non-witnessed fall will be observed for neurological abnormalities by performing neuro check, per policy. The physician will be notified of any abnormal findings. -The resident's representative will be notified of the fall and any follow-up treatment needed. -The staff should document the circumstances of the fall, complete a post-fall assessment, and document resident's fall under risk management, a change of condition, and on the 24 hour report. II. Resident #16 A. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #16, age 70, was admitted on [DATE]. According to the July 2022 computerized physician orders (CPO), diagnoses included displaced spiral fracture of the shaft of humerus, left arm, subsequent encounter for fracture with routine healing (onset 7/26/22), hemiplegia and hemiparesis (paralysis, muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, epilepsy, history of falling, unsteadiness on feet, muscle weakness, abnormalities of the gait and mobility, visual loss, and anxiety. The 4/27/22 minimum data set (MDS) assessment identified the resident was not able to complete the brief interview for mental status (BIMS) assessment. According to the MDS, Resident #16 had moderately impaired cognition, made poor decisions and needed cuing and supervision. He did not exhibit disorganized thinking or inattention. The MDS identified he required extensive assistance of more than two staff for toileting, dressing, bed mobility and transfer. He required one person's physical assistance for personal hygiene. The MDS indicated the resident had a history of falls with injury. B. Resident observation and interview Resident #16 was interviewed on 7/26/22 at 9:18 a.m. He said his shoulder was uncomfortable and was told he would have an x-ray today (7/26/22). He said he recently fell in the bathroom. The resident's left arm was under his blanket as he laid flat in bed. Resident #16 was interviewed on 7/27/22 at 10:18 a.m. The resident was observed in his bed, he wore a sling on left arm. He said he had x-ray yesterday (7/26/22). The resident clearly described how he was injured. He said took himself to the bathroom. He stood up from the toilet, lost his balance and fell into the door. He said he pulled himself up by using a wall mounted bar and went back to his bed. He said he told a certified nurse aide (CNA) what happened. He said he did not know the CNA's name. Resident #16 said the fall in the bathroom was recent. He said the fall in the bathroom was after the fall when he received significant injuries to his face. C. Record review The fall care plan, last revised on 5/20/22, read Resident #16 was at risk for falls related to his history of CVA (cerebrovascular accident/stroke), hemiplegia and recent TBI (traumatic brain injury.) The care plan identified the resident had multiple falls with injury. Review of the care plan revealed the resident had no new interventions related to falls. The most recent intervention initiated on 11/27/19 and revised on 5/20/22, read the resident's last physical therapy (PT) evaluation and treatment was initiated on 4/10/22. The skin care plan, initiated on 2/18/21, identified the resident was at risk for skin breakdown and had a history of falls with injury. The care plan directed staff to observe the resident's skin daily and report abnormalities. The care plan for the resident had new interventions beginning on 7/22/22 directing staff to: -Apply lower and upper extremity protectors. -Observe for verbal and nonverbal signs of pain related to wound or wound treatment and administer medication as ordered. -Conduct weekly wound assessment with measurements and descriptions of the wound status. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 6/12/22 hospital emergency department evaluation read Resident #16 had facial trauma from a fall. The evaluation identified the resident had x-rays and a CT (computer axial tomography) scan. The x-rays showed the resident had multiple facial fractures. The evaluation findings read the resident had no other fracture, dislocation, or other acute bony abnormality. The 6/13/22 e-interact change in condition evaluation identified the resident fell the afternoon on 6/12/22. He did not express discomfort. The resident was sent to the emergency room for testing and x-rays. The evaluation read the resident had laceration sutures to his upper orbital area of his face. According to evaluation, the 6/12/22 x-rays determined the resident had facial fractures. -The evaluation did not identify the resident had fractures to any other part of his body based on the x-ray results. The 6/15/22 nurse practitioner evaluation read the resident was seen on 6/15/22. The evaluation read the resident did not have discomfort. -The evaluation did not indicate the resident expressed pain or concern with his left shoulder and arm. The pain scale between 7/1/22 and 7/12/22 identified Resident #16 reported zero to four out of 10 for pain with one reported pain level of five on 7/7/22. The 7/5/22 physician evaluation performed by the primary care physician (PCP) read the resident was seen on 7/5/22. The evaluation read there was no acute concerns with Resident #16 and he was eating, drinking and sleeping well. According to the evaluation, the resident was not in acute distress, not acutely ill, and not uncomfortable. The 7/5/22 physician note read Resident #16 was sent to the hospital due to facial fractures. The note did not indicate a concern with his left shoulder. The 7/5/22 skin check read the resident's laceration to his left eye was in the healing process. -The skin check did not identify a bruise or contusion to his left arm. The 7/14/22 at 4:05 a.m. general note read a CNA said Resident #16's arm was swollen and bruised. The general note identified the resident requested an x-ray. The resident was assessed (see note below). -There were no additional follow up notes pertaining to the resident's arm or shoulder or if the injuries were a result of a fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 7/14/22 at 6:45 a.m. e-interact SBAR (situation, background,assessment, and recommendation) form read Resident #16 had a change in condition. According to the SBAR, the resident had new or worsening edema, new or worsening pain and a contusion (bruise). The SBAR nursing observations, evaluation, and recommendations read Resident #16's arm was swollen and bruised. There was edema present from shoulder to wrist with a 4 (inch) linear, deep purple bruise surrounded by yellow bruising, presumably from fall on 6/13/22. Weak pulse palpable on the left wrist and slightly colder than right. The SBAR read the resident requested an x-ray. The SBAR indicated there was a concern regarding a possible occlusion/blockage. The on call physician was contacted and recommended to alternate heat and ice and then elevate. The SBAR read heat was applied to the resident and his arm elevated. The resident's primary physician was also notified. -The SBAR did not identify if the primary physician offered recommendations and or new interventions. The pain scale beginning on 7/13/22, identified the resident expressed an increase of pain to his left arm. On 7/13/22 he reported a pain level of six. The pain scale on 7/14/22 identified Resident #16 reported a pain level of six. The 7/14/22 at 4:49 p.m. text message between unit manager (UM) #1 and the physician was provided by the UM on 7/27/22 at 11:59 a.m. According to the text message, the UM informed Resident #16's primary care provider/physician (PCP) that Resident #16 had complained of pain since the fall in June 2022. His arm was assessed (on 7/14/22) and his muscle was hard, tight, and painful. Resident #16 had edema to his lower arm and had horrible pain with minimal movement. The UM informed PCP that the UM and the director of nursing (DON) assessed the resident and felt he required further assessment. The PCP told the UM she saw Resident #16 on the afternoon of 7/14/22 and provided orders to registered nurse (RN) #1 via text. The PCP indicated the x-rays in the emergency room (prior to 7/14/22), were normal. The PCP identified she felt the resident had a rotator cuff injury. The 7/15/22 CPO read the resident had orders for PT to evaluate. The orders did not indicate the reason for the evaluation. The 7/15/22 CPO identified the resident had a new order for pain medication. The 7/15/22 order directed staff to administer 650 milligrams (mg) acetaminophen tablet, by mouth, three times a day for left upper extremity (pain) for 14 days. The review of the CPO between 7/15/22 and 7/26/22 did not identify the resident had orders to immobilize the left arm/shoulder to provide support when the resident expressed increased pain and exhibited swelling to the arm. -The CPO did not identify an order for an x-ray after the resident requested the x-ray on 7/14/22. The pain scale on 7/17/22 identified Resident #16 reported a pain level of six. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 7/19/22 physical therapy (PT) evaluation, conducted five days after the PT evaluation order and over a month after the resident fell on [DATE], indicated Resident #16 was referred to therapy due to a fall on 6/12/22 and was found on his left side. He complained of shoulder pain and has had a decline in transfers. The x-ray results (following the 6/12/22 fall) identified the resident was negative for a fracture. The PT evaluation revealed the resident was in a good deal of pain. The PT evaluation pain assessment indicated the resident had a pain intensity of eight out 10, located in his upper left arm/shoulder. The evaluation read PT would communicate to staff therapy's findings and determine if further testing of the left shoulder was indicated. The 7/20/22 CPO read Resident #16 had orders for physical therapy due to decline in transfer and shoulder pain. The 7/20/22 PT treatment encounter note read Resident #16 complained of left shoulder pain during treatment and did not want his left arm moved. The note read Resident #16 told PT it's broken! The PT note identified the resident's arm was swollen and painful. The therapist contacted the PCP who reported told PT Resident #16's x-ray was negative. The evaluation suggested if the resident did not have tolerance for range of motion (ROM), he may need to revisit diagnostics. The 7/20/22 handwritten physician orders were provided by the facility on 7/26/22. According to the orders, Resident #16 had an order for an x-ray for left shoulder pain. The 7/20/22 skin check read Resident #16 had a skin injury. -The skin check did not identify what or where the skin injury was. The skin check did not identify the resident had a bruise or the condition of the bruise. The 7/22/22 skin check read the resident had an open area on the middle of his right hand. -The skin check did not identify the resident had a bruise or the condition of the bruise. The appointment log was provided by the facility on 7/28/22. The log identified Resident #16 had an appointment request submitted on 7/25/22. The request read the resident needed an x-ray on his left shoulder STAT (urgent) signed by UM #1. The 7/25/22 request had a line drawn through it. The status of the appointment was left blank. The appointment log identified a second appointment request was made on 7/26/22. The 7/26/22 appointment request was not marked STAT. The status of the appointment was dated 7/27/22, indicating the appointment was completed. The resident appointment log identified the resident had an appointment scheduled for an x-ray, six days after the resident had orders for the x-ray. The 7/26/22 alert note at 12:28 p.m. read the hospital informed the facility that Resident #16 had a spiral fracture to the left humerus. The resident was provided a shoulder immobilizer to keep mobile. According to the alert note, the hospital informed the facility Resident #16 would send results to orthopedics. The hospital indicated the resident probably would not need surgery. The identified Resident #16 would have physical therapy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 7/26/22 review and 30 day look back of the facility in house and reported investigations after incident occurrence, did not identify the facility conducted an investigation for a fall or a bruise of unknown origin after the resident had a swollen arm with a large four inch purple bruise on the early morning of 7/14/22. D. Staff interview Registered nurse (RN) #1 was interviewed on 7/26/22 at 9:25 a.m. He identified he was Resident #16's regular nurse. He confirmed Resident #16 was scheduled for an x-ray on 7/26/22. The RN said the PCP had already evaluated the resident's arm. RN #1 said the resident's swollen arm and deep purple bruise could have been from the fall on 6/12/22 or because the resident did not often move his left arm due to hemiplegia/hemiparesis. He said he was not aware of any falls the resident may have had after 6/12/22. He said the resident was seen by therapy related to his arm. RN #1 was interviewed again on 7/27/22 at 9:23 a.m. The RN said Resident #16's x-ray indicated the resident had a broken shoulder. He said the resident now had a sling. The RN acknowledged the broken shoulder could have occurred on or around 7/14/22. He said the staff originally thought the bruise was from a blood clot and contacted the physician. He said the physician evaluated the resident's arm and ruled out a blood clot. He said he was aware the resident requested an x-ray however the resident often complained of pain. The RN said the facility received orders for an x-ray from the physician. RN #1 said he was not aware of an x-ray appointment delay after the facility received orders. He said the appointment scheduler/facility driver (FD) was responsible for scheduling the x-ray. The RN said he still believed the injuries were caused by the 6/12/22 because no one reported a fall to him. He said it was possible the hospital did not identify the shoulder fracture at that time. The RN said the resident can not use his arm because of a stroke, so it was possible the change was not identified by staff. The RN said he did not observe the deep purple bruise or swelling of the arm prior to 7/14/22. The RN acknowledged the inability to use the arm would not cause a bruise and a fracture. The PCP was interviewed on 7/27/22 at 10:49 a.m. The PCP said she evaluated Resident #16's arm after staff reported to her of his edema and bruising. She said the resident has a history of behaviors and would at times not want people in his room. She said she was able to distract the resident's behaviors with conversation and aggressively move his arm. The resident did not express pain at that time (7/14/22). The PCP said she identified the resident's arm was swollen over his bicep. She said based on her assessment, she felt the resident had a bicep tear or rotator cuff injury. She said the resident did not have a blood clot. The PCP ordered the resident pain medication and physical therapy to evaluate him. She did not recall if staff reported to her Resident #16 was having an increase in pain. She said she was not informed the resident requested an x-ray on 7/14/22. The PCP said she asked the resident what happened and he said he did not know. The PCP said the 7/26/22 x-ray results determined the resident had a fracture to his shoulder. The PCP said the fracture would not have been a result of the 6/12/22 fall. She said the resident's prior x-ray after his 6/12/22 fall, identified he had facial injuries but the other bones were normal. The PCP said the shoulder fracture would have been a new occurrence. She said something happened to cause the injuries. The NHA was interviewed on 7/27/22 at 11:10 a.m. The NHA said investigations were conducted when a resident had a bruise of unknown origin. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 7/27/22 at 11:22 a.m. She said she was new to the facility. She said she had limited knowledge of concerns related to Resident #16 on 7/14/22 but was aware he was expressing pain. She said she had UM #1 assess the resident on 7/14/22. His arm was swollen and hard. He had a bruise and pain. She said the PCP was contacted and had already seen the resident on 7/14/22. The physician thought the resident had a rotator cuff injury. The DON said an x-ray was ordered last week (7/20/22) when the physician was informed that the resident's pain and swelling had not improved or resolved. The DON acknowledged the resident did not have an x-ray until 7/26/22, six days after the resident had an order for the x-ray. The DON said it would be the expectation for the resident to have an x-ray on the same day of the orders. The DON confirmed there was a long delay between the time the order was made for an x-ray and the time he had an x-ray. She said she was not sure if the FD was aware of the 7/20/22 orders on 7/20/22. She said the facility was in process of implementing a new appointment system with the nurses and the FD. The nurses would write the appointment request in the appointment book, identify what the appointment was for, and write STAT if it was urgent. The FD should review the book several times a day to identify new changes or add ons to the appointment requests. She said she would educate staff of the new process. The DON identified the resident had not had the 7/20/22 physician ordered x-ray until 7/27/22. The DON said she told the FD on 7/26/22, the resident needed the x-ray now. The DON said because she was new, she was not fully aware of the appointment process before the implementation of the new process. She said she just knew it was unorganized. The UM #1 was interviewed on 7/27/22 at 11:39 a.m. She said she had been in her position for a few weeks. The UM said she was aware Resident #16 had a fall in June 2022 and an x-ray after the 6/12/22 fall. He started reporting pain a couple of weeks ago. She said on 7/14/22 the nurse identified the resident had a swollen arm, and pain. The resident was assessed. His bicep was hard, swollen and had an old green and yellow bruise and a purple bruise in the same area. The UM said she was concerned with the resident's pain level and hardened bicep. She said she texted the PCP, reporting the resident was in horrible pain with minimal movement. She said a couple weeks after 7/14/22, it was reported that the resident was having pain during transfers with PT on 7/20/22. The UM said she was scheduled off work a few days after 7/20/22. She said on 7/25/22 she saw an order on 7/20/22 for the x-ray laying on top of the appointment book and the identified the resident still did not have the x-ray. She said she informed the FD of the appointment. The FD was interviewed on 7/27/22 at 5:16 p.m. The FD identified he was a CNA, the facility driver and appointment scheduler. He said he received physician referrals for appointments. He said he found out what the resident needed the appointment for, identified where he could take the resident for the appointment, contacted the appropriate medical service site, and coordinated his schedule to provide transportation to the appointment and asked the resident if they agreed with the appointment time. The FD said he could not force a resident to go to the appointment. The FD said with the old process, the nurse handed him an order with the appointment that needed to be scheduled. Now, there was an appointment book that he used to schedule the appointments. The FD said he planned on taking Resident #16 to have x-rays on 7/22/22. He attempted to ask the resident on 7/20/22 if he could take the resident to the appointment on 7/22/22 but the resident was having behaviors that day and was not approachable. The resident was in pain and mad. The FD said he planned on re-approaching the resident on 7/22/22 but did not because the resident was yelling at everyone. The FD said Resident #16 had a good rapport with the laundry aide. He said he did not think of asking her to ask the resident he would go to the appointment on 7/22/22. The FD said he may try that approach in the future. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	The FD said he canceled the 7/22/22 appointment. He said he did not communicate to anyone that he canceled the 7/22/22 appointment except for RN #1 and the CNAs were aware of the resident's behaviors that day and that he was not approachable. The FD said on 7/26/22 the resident was in a good mood and the FD was able to take Resident #16 to the appointment. The resident agreed and had the x-ray on 7/26/22. The FD said no one approached him on Monday 7/25/22 regarding Resident #16's appointment. He had some appointments and had a resident shopping trip scheduled but would have taken the resident if the appointment urgency was expressed or it was communicated that the resident needed to be seen STAT. He said if he knew the appointment was urgent, then he would have coordinated his schedule to make it work. UM #1 was interviewed again on 7/27/22 at 5:25 p.m. She said on 7/25/22 she wrote STAT next to the resident's appointment request but was aware the FD was fully booked on 7/25/22. The UM was asked if she considered to send Resident #16 by ambulance when the x-ray appointment was considered STAT. The UM said she did not consider having the resident go out by an ambulance to the appointment because STAT did not come from the physician. The rehab/therapy service director (RSD) was interviewed on 7/28/22 at 10:32 a.m. The RSD said Resident #16 received therapy services in April 2022 till May 2022. She said the resident did have orders to be seen in June 2022, after the resident fell on [DATE]. She said the resident had x-rays on 6/12/22 in the hospital emergency department, which were negative for a shoulder fracture. She said in July 2022, the resident had new orders to evaluate the resident for transfer training, pain and history of falls. She said she was not aware if the resident was expressing pain prior to 7/14/22 but was aware the resident had pain after 7/14/22. She said the resident was evaluated on 7/19/22. The RSD said during 7/20/22 therapy treatment, the resident complained of pain and reported to PT that he thought his shoulder or arm was broken. The RSD said the physician was contacted with PT's observation and the resident's concern. The NHA was interviewed on 7/28/22 at 7:30 p.m. The NHA said it was a routine intervention for a resident to have a therapy evaluation after a fall. She said she was not sure why the resident did not have an order for therapy after his 6/12/22 fall. The NHA said staff should have been more assertive with the physician of their concerns after they assessed the resident for a change in condition. The NHA said it would be appropriate to send a resident to an x-ray appointment if the FD was not available. The NHA said she would have instructed staff to start an investigation for the bruise of unknown origin if she was aware of staff findings on 7/14/22. E. Facility follow up (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON provided a 7/27/22 staff education on 7/27/22 at 11:22 a.m. The education informed staff of a new process in appointment scheduling. According to the education, the process was discussed a week prior. The process included appointment requests logged in a binder and the requests would include the diagnostic request such as x-rays, CT scans, etc. Nursing staff was responsible for initiating the requests and the scheduler was responsible for reviewing daily. The schedule needed to indicate the appointment had been scheduled and completed on the log. The scheduler would notify the resident and the resident's power of attorney (POA) with the upcoming appointment date and time. According to the education, appointments needed to be scheduled daily, and the scheduler should not wait days to make the appointment. The education read Appointments are very important and are not to be rescheduled for lack of time or transportation. The education informed staff that appointments should only be rescheduled per the resident or physician request. The education identified the facility had both had back up drivers and residents also use a transportation service vendor for appointments. The 7/27/22 education for resident refusal of an ordered treatment was provided by UM #1 on 7/28/22 at 10:18 a.m. According to the education, if a resident refuses an ordered treatment, the refusal, the reason for the refusal, the education to the resident, and the PCP notification must be documented in a progress note in the resident's medical chart. The 7/27/22 education for fall charting was provided by UM #1 on 7/28/22 at 10:18 a.m. According to the education, all falls in the facility must be charted under risk management and a change of condition must be completed. Neurological checks must be initiated for unwitnessed falls with a suspected head injury. The PCP, the POA, and the on-call nurse must be notified of all falls and incidents. 40840 III. Resident #316 A. Resident status Resident #316, age 77, was admitted on [DATE]. The July 2022 computerized physicians orders (CPO) included diagnoses of dementia with behavioral disturbance, major depressive disorder, and weakness, and lack of coordination. A minimum data set (MDS) with brief interview for mental status (BIMS) was not performed as the resident was a new admission. B. Record review Resident #316's care plan for falls, initiated 7/8/22, the date of admission, focused on cognitive loss, lack of safety awareness, impaired mobility, and seizures. Interventions implemented to prevent falls included: -Assist resident to organize belongings for a clutter free environment in the resident's room for consistent furniture arrangement (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Observe for changes in medical status, pain status, mental status and medication side effects that may contribute to cognitive loss/dementia/delirium and can lead to increased fall risk, and report to physician as indicated. -Arrange patient's environment to enhance vision and maximize independence -Bed in low position -Gently guide the resident from the environment while speaking in a calm, reassuring voice when needed. -Observe for signs/symptoms of depression and anxiety and promote self-management strategies. -The care plan was not updated or modified after the initiation date of 7/8/22, although the resident experienced repeated falls and injuries. A nursing note on the day of admission, 7/8/22 at 5:55 p.m., showed the resident was admitted to the facility at 4:45 p.m. with goals for physical therapy (PT) and occupational therapy (OT). She was noted to have advanced dementia with inability to understand her reason for admission. She was noted to be confused but oriented to person only and to be unsteady with transferring from surface to surface as well as unsteady with transferring to the toilet, but she was able to stabilize with staff assistance. The resident was noted to be experiencing agitation and restlessness. The resident was noted to have a past medical history of cancer, dementia, seizure, and poor safety awareness. The 7/8/22 admission fall risk assessment, included with the nursing assessment, documented no falls in the last two to six months prior to admission, and no falls in the last month prior to admission/readmission. -The resident's fall risk was otherwise not assessed. 1. Fall #1 A situation, background, assessment, and recommendation (SBAR) note on 7/9/22 at 12:00 a.m., the night of admission, reported the resident's first fall in the facility. The nursing observations section read, CNA alerted me that resident had fallen in her bedroom. Resident was found curled in a ball between the bed and[TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for 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** 40467 Based on observations, record review and staff interviews, the facility failed to ensure one (#34) of two residents observed for nutrition/hydration maintained acceptable parameters of nutritional status to avoid unintended weight loss out of 29 sample residents. Specifically, the facility failed to timely address Resident #34's weight loss. Findings include: I. Facility policy and procedure The Nutrition/Hydration Management policy, revised 6/1/21, was provided by the nursing home administrator (NHA) on 7/28/22. According to the policy, staff would consistently observe and monitor residents for changes and implement revisions to the plan of care as needed. The policy identified staff should: -Review appropriate assessment information. -Address and new changes pertinent to the resident's nutritional needs/status with dietitian and physician. -Review the dietitian's recommendations. -Develop an interdisciplinary plan of care for enhancing oral intake and promoting adequate nutrition and hydration. -Monitor resident's weight. -Revise the resident's care plan as needed. II. Resident #34 A. Resident status Resident #34, age 82, was admitted on [DATE]. According to the July 2022 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus without complications, congestive heart failure, morbid (severe) obesity, vascular dementia, sequelae of cerebral infarction (residual effects from stroke). The 6/14/22 minimum data set (MDS) assessment revealed the resident's cognition was severely impaired with a brief interview for mental status (BIMS) score of two out of 15. The resident required extensive physical assistance with two or more persons for bed mobility and toileting. He needed extensive physical assistance from one person for dressing, and personal hygiene. Resident #34 needed supervision of one person for eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS indicated Resident #34 did not have a weight loss of 5% or more in a month in the MDS look back period and did not have a 10% weight loss or more in the six months prior to 6/14/22. There were no identified concerns with the resident's oral/dental status or swallowing. B. Observations Resident #34 was observed on 7/25/22 during the noon meal. The resident ate about 75% of his meal and requested his tray to be removed from his room. The resident did not express concerns with the meal. C. Record review The 6/30/22 CPO read to weigh the resident monthly starting on the first of the month. The 8/30/21 CPO read Resident #34 had an order for a house supplement three times a day for weight maintenance and wound healing. The 2/24/22 CPO read Resident #34 had an order for a two gram sodium 1800 calorie diet. The 7/26/21 CPO read Resident #34 had an order for liquid protein for wound healing. The CPO identified the liquid protein was not ordered for weight management. The nutrition care plan, initiated on 7/6/21, last revised 1/4/22, read Resident #34 received insulin and was on diuretic therapy. According to the care plan, house supplements between meals for weight stability. The care plan read a gradual weight loss of two pounds per week and a body mass index of 24% to 30% would be beneficial for optimal health. The care plan identified Resident #34 had no new interventions added to the care plan after 8/30/21. The last nutrition intervention, initiated on 8/30/22 directed staff to provide and serve supplements as ordered. -There were no new interventions after significant weight loss was identified on 7/1/22 as indicated in the weight record (see below.) The weight record identified Resident #34 lost 15.8 pounds (lbs) between 6/7/22 and 7/1/22. Resident #34 lost 7.14% of his body weight, which was considered significant weight loss. The weight record read as follows: -6/2/22, Resident #34 weighed 221.4 lbs by use of the bath scale. -6/7/22, Resident #34 weighed 221.4 lbs by use of the mechanical lift scale. -7/1/22, Resident #34 weighed 205.6 lbs lbs. by use of the bath scale. Resident #34 had the same weight (221.4 lbs) on two different scales a week apart. The scale indicated the resident lost 15.8 lbs from 6/7/22 and 7/1/22. A re-weigh was requested, however was not completed (see staff interviews below). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The weight record identified the resident had more than a two pound weight loss per week between 6/7/22 and 7/1/22. The last nutritional assessment, dated 6/14/22 read Resident #34 has had a gradual weight loss of 13% or 33.6 lbs in the past year, which was considered desirable due to history of obesity. According to the assessment, the resident's current (based on the 6/7/22 weight) body mass index (BMI) suggested the resident had an overweight status at 31.8%. The nutritional assessment read the resident remained on a two gram sodium diet with regular texture. He ate in his room and required limited assistance. Resident #34 received and accepted the house supplement three times a day (TID) and liquid protein twice a day (BID) to promote tissue regeneration. The 6/14/22 nutritional assessment read the resident's meal intakes were back to baseline at 76-100% intake average with meals, after Resident #34 was treated for antibiotics for a urinary tract infection (UTI). According to the assessment, the resident used a diuretic which may cause weight fluctuations but the weight was stable for the past 180 days (per the 6/7/22 weight.) The nutritional assessment read Resident #34's had no new nutritional concerns at this time and no significant weight changes. -The registered dietitian did not re-assess Resident #34 after the resident was recorded to have lost 15.8 lb between 6/7/22 and 7/1/22. The 6/22/22 weight report, labeled NAR (nutrition at risk) meeting, was provided by the NHA on 8/1/22 via email. The weight report identified Resident #34 weighed 221.4 lbs the week on 6/8/22 and 222.6 lbs, 180 days prior to the 6/8/22 week weight. -The weight report did not identify a weight concern for Resident #34. A 7/21/22 email, provided by the NHA on 7/28/22 at 6:14 p.m, was sent between the RD, the weekend supervisor, both unit managers (UM) #1 and UM #2, and the NHA. The email identified the residents reviewed during the nutrition at risk (NAR) meeting minutes/review, on the week of 7/11/22. -The minutes identified Resident #34 was not reviewed during the NAR meeting. D. Staff interviews The registered nurse (RN) #1 was interviewed on 7/28/22 at 8:50 p.m. He confirmed Resident #34 had not had a weight taken since 7/1/22 after the resident lost 15.8 lbs. He said he would have the staff to weigh him. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The registered dietitian (RD) was interviewed on 7/28/22 at 3:50 p.m. She said residents with weight concerns were discussed in the nutrition at risk (NAR) meetings. During the recent NAR, the RD said she expressed a concern with the use of different scales potentially creating weight fluctuations with residents. She said if staff identified a large swing in weight in either a loss or gain, the resident should have been reweighed. The RD said she believed Resident #34 was reviewed in NAR at the beginning of July 2022. The RD said she was aware of the weight loss but was waiting for staff to reweigh him to ensure accuracy. She said staff were using different scales on residents each time they were weighed causing variations in the weights. The weight loss was reviewed with the RD who confirmed the use of the scales would not have impacted Resident #34's weight on 7/1/22 because the same scale, the bath scale,was used on 6/2/22 and 7/1/22. The staff used the mechanical lift scale on 6/7/22 but the weight was the exact same as the bath scale on 6/2/22. The RD said there were no new interventions after the recorded 7/1/22 weight loss except for staff to reweigh him. She wanted to make sure it was a true weight loss and eliminate possible error. The RD said Resident #34 was not discussed during the 7/21/22 NAR because she was still waiting for staff to reweigh. The RD said Resident #34 was already on a prescribed weight loss plan. She said the goal for the weight loss was one to two lbs. The RD confirmed the resident had a greater than one to two lb weight loss per week, between 6/2/22 and 7/1/22. She said the 7% weight loss in a month was faster than what was recommended. The RD said Resident #38 had good meal intake. The resident was already on house supplements and Prosat and the resident still lost weight. The RD said communication with the facility needed to improve, and share concerns promptly so they could be addressed and fixed. She said there has been a lot of staff turnover. She said she would like to have set staff assigned to collect residents weights, and use the same scale for each weight. She said moving forward she would request staff to reweigh residents if there was more than a 5% change in weight. She would request nurse management to bring to her attention a list of residents they were concerned about or had weight loss so interventions, medication adjustments and lab work and other potentially triggering factors could be reviewed. She said would work with the DON to improve the process. The NHA and the director of nursing (DON) was interviewed on 7/28/22 at 7:05 p.m. According to the NHA and the DON, staff should reweigh a resident to determine if the weight loss was accurate. If the weight loss was significant and determined to be accurate, the RD would be notified so she could make a recommendation or intervention. The NHA said she was not aware Resident #34 had weight loss. She said staff should have reweighed him as soon as a weight change was identified. She said they would have reviewed his labs, diet, and intake. The resident should have had additional weights over the last month to monitor his weight. The NHA said the facility had a recent nursing management change of the last few weeks and now has a new DON and two new unit managers. The nurse management team will focus on symptom improvements such as weight monitoring. She said the facility would also focus on streamlining communication between the facility and the RD. III. Facility follow-up (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/27/22 staff education read nursing staff at the start of their shift must identify if residents' weights were due and inform the CNAs who needed to be weighed. According to the education, CNAs must weigh the identified residents before breakfast and on the same specific scale used to collect prior weights to ensure weight accuracy. The education informed staff that weights could not be missed. The education directed staff to reweigh the resident if there was a significant gain or loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on observations, record reviews, and interviews, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for one (#43) of one out of 29 sample residents. Specifically, the facility failed to ensure oxygen was administered according to physician orders for Resident #43. Findings include: I. Professional reference According to [NAME]/[NAME], Fundamentals of Nursing, ninth edition, Elsevier, Canada, 2017, p 900, Oxygen is a therapeutic gas and must be prescribed and adjusted only with a health care provider's order. II. Facility policy The Oxygen Concentrator policy, revised on June 6, 2022, was provided by the nursing home administrator (NHA) on 7/28/22. The policy read in pertinent part, Verify order, set liter flow per order, document, the date and time oxygen started, method of administration, liter flow, and patient's response to therapy. III. Resident #43 A. Resident status Resident #43, age 86, was admitted on [DATE]. According to the July 2022 computerized physicians orders (CPO), diagnoses included unspecified heart failure, chronic atrial fibrillation, dementia in other diseases classified elsewhere without behavioral disturbances, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. The 3/16/21 minimum data set (MDS) assessment showed the resident had minimal cognitive impairments with a BIMS score of 13 out of 15. The resident required extensive assistance with mobility and with personal hygiene. The resident was coded as using oxygen. B. Observations 7/25/22 -At 11:03 a.m. the resident did not have her oxygen cannula on, however, the concentrator was set at three liters per minute (LPM). -At 11:43 a.m., the oxygen cannula was not on the resident. The concentrator was set at three LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/26/22 -At 12:59 p.m., the oxygen cannula was not on; the concentrator was set at three LPM. -At 1:58 p.m., the oxygen cannula was not on the resident, however, the concentrator was set at three LPM. -At 3:13 p.m., the resident had the oxygen cannula on, and the oxygen was set at three LPM. -At 3:23 p.m., the resident was observed to remove her oxygen. The oxygen was set at three LPM. -At 3:43 p.m., certified nurse aide (CNA) #2 went in to assist Resident #43 in her room. She picked the cannula off the ground, threw it over the table, and left the room. She did not assist to put the oxygen cannula on the resident. -At 3:44 p.m., licensed practical nurse (LPN) #2 entered Resident #43's room and failed to place the oxygen back on resident -At 3:48 p.m., LPN #2 was observed to remove the cannula off of the bedside table and placed it into her nose. LPN #2 did not clean the cannula prior to placing it into her nose. 7/27/22 -At 8:07 a.m., Resident #43 was sleeping, and the oxygen cannula was wrapped and on the concentrator. The concentrator was on and set at three LPM. -At 8:24 a.m. LPN #2 entered resident #43's room and failed to put oxygen back on the resident. -At 9:47 a.m., the oxygen cannula was not on the resident, and the concentrator was set at three LPM. -At 10:12 a.m., the oxygen cannula was not on, and the concentrator was set at three LPM. -At 10:14 a.m. LPN #2 woke up the resident to administer medications, however, she did not place the oxygen onto the resident, prior to leaving the room. -At 10:40 a.m., the oxygen was not on the resident, but the concentrator was running and set to three LPM. -At 10:50 a.m., LPN #2 observed the resident did not have the oxygen cannula on, however, the concentrator was set at three LPM. She then placed the cannula on the resident and adjusted the liter flow to one LPM. She did not check the resident's pulse oxygen saturation level before adjusting the amount of oxygen. C. Record review (continued on next page)

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	065110	A. Building B. Wing	07/28/2022

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July 2022 CPO documented a physician order for oxygen ordered on 7/20/2020, to be on night and day shifts, at 1 liter per minute (continuously), delivered through NC (nasal cannula). After treatment, evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds. D. Interviews LPN #2 was interviewed on 7/28/22 at 10 30 a.m. LPN #2 reviewed the physician orders. She stated that she should be on one LPM and that her oxygen should be on at all times per the physician's order. She said that if the resident refused the oxygen then it would be documented on the resident's medication administration record (MAR). The director of nursing (DON) was interviewed on 7/28/22 at 4:00 p.m. The DON said the oxygen orders needed to be checked regularly to ensure that nursing staff were following doctors' orders. She said the resident should be observed by the licensed nurse to ensure that oxygen was on and at the proper setting.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42193 Based on interview, and record review, the facility failed to ensure for one (#30) of five residents reviewed for the use of unnecessary medications out of 29 residents were free from unnecessary drugs. Specifically, the facility failed to ensure gradual dose reduction (GDR) was attempted for Resident #30 who was administered psychotropic medications. Findings include: I. Facility policy and procedure The Unnecessary Medication policy, revised 7/1/21, was received from the nursing home administrator (NHA) on 8/1/22 at 12:32 p.m. It read in pertinent part: Patients who exhibit behavioral symptoms will be individually evaluated to determine the behavior. Based on the comprehensive assessment, staff must ensure that a patient: Who displays or is diagnosed with mental disorders receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. Behaviors and interventions will be addressed in the care plan. Behavior rounds are recommended as a best practice to identify and manage behavioral symptoms. Staff will monitor for and document in the medical records any exhibited behavioral symptoms which include, but are not limited to: Verbally aggressive behaviors such as threatening, screaming, cursing, insulting, or intimidating others; Physically aggressive behaviors, such as hitting, kicking, grabbing, scratching, pushing, biting, spitting, threatening gestures, throwing objects; sexually inappropriate behaviors such suggestive sexual comments, public masturbation, unnecessary self exposure or touching of others and wandering that places resident at significant risk in getting to a dangerous place or significantly intrudes on the privacy or activities of others. II. Resident #30 Resident #30, age 86, was admitted on [DATE]. According to the July 2022 computerized physicians orders the diagnosis included type two diabetes, Alzheimer's disease, dementia with behavioral disturbance,and need for assistance with personal care. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 6/15/22 minimum data set (MDS) the resident was severely cognitively impaired, could not understand others and could not be understood by others.The resident required supervision with bed mobility and transfers. She also required limited assistance with dressing and toilet use.The resident exhibited no behaviors and was coded receiving antidepressant medications. The MDS indicated a gradual dose reduction of Resident #30 medications were not requested. III. Record review Physicians orders for Resident #30 indicated: -Depakote 250 mg tab one tab two times per day for dementia, agitation and psychosis with start date of 12/11/21. -Trazodone 50 mg tab for restlessness, one tab by mouth in the evening, started on 6/21/21. -No GDR had been done for the Depakote or the Trazodone medication identified in the resident ' s medical record. IV.Interviews Certified nurse aide (CNA) # 1 was interviewed on 7/28/22 at 11:00 a.m. She said the resident had presented some behaviors lately and she thought it was due to a urinary tract infection (UTI). She said the resident usually did not exhibit behaviors. Licensed practical nurse (LPN) #4 was interviewed on 7/28/22 at 3:58 p.m. He said there was no GDR for the Depakote and Trazodone medication. He said there was no need for GDR because the medication was helping the resident and stabilized her mood. The NHA and director of nursing (DON) were interviewed on 7/28/22 at 6:00 p.m. The NHA said there was a psychotropic review in the medical record for Resident #30 on 7/26/22 with no irregularities found. The DON said she could not find a GDR for Resident #33 Depakote and Trazadone in the medical record. The NHA said consent required for increase or decrease in dose should be assessed twice a year. The DON said a gradual dose reduction needs to take place for a resident's medication when the resident had not had one in over six months and was taking antipsychotic medication or medications for depression and behaviors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40840 Based on observations, interviews and record review the facility failed to ensure residents were kept free from significant medication errors for two out of 29 sample residents. Specifically, the facility failed to ensure insulin pens were primed prior to medication administration on two occasions. Findings include: I. Professional reference According to Novo Nordisk, Novolog Flexpen, 2022, https://www.novolog.com/type-2-diabetes/just-heard-about-novolog-t2/novolog/using-flexpen.html (Obtained 8/3/22): Preparing your (insulin pen) -Wash your hands. Check the label to make sure that you are using the right type of insulin. This is especially important if you take more than 1 type of insulin -Pull off the pen cap. Wipe the rubber stopper with an alcohol swab -Remove the protective tab from the needle and screw it onto your FlexPen(R) tightly. It is important that the needle is placed on straight -Never place a disposable needle on your FlexPen(R) until you are ready to take your injection -Pull off the big outer needle cap and then pull off the inner needle cap. Throw away the inner needle cap right away -Always use a new needle for each injection -Be careful not to bend or damage the needle before use -To reduce the risk of needle stick, never put the inner needle cap back on the needle Doing the airshot before each injection Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: -Turn the dose selector to 2 units -Hold your (insulin pen) with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle -If no drop appears, change the needle and repeat. If you still do not see a drop of insulin after 6 tries, do not use the (insulin pen) and contact (manufacturer). A small air bubble may remain at the needle tip, but it will not be injected. II. Facility policy and procedure The Insulin Pens policy, revised 6/1/21, provided by the nursing home administrator (NHA) on 7/28/22 at 10:36 a.m. read in pertinent part, insulin pens containing multiple doses of insulin are meant for single patient use only and must never be used for more than one person, even when the needle is changed. Insulin pens will be clearly labeled with the patient name and other identifiers to verify that the correct pen is used on the correct patient. Practice standards included: -Never use a syringe to draw insulin out of an insulin pen. -Store insulin pens at room temperature. -Insulin pens are to be primed prior to each use to prevent the collection of air in the insulin reservoir III. Observations and interview On 7/27/22 at 5:35 p.m. licensed practical nurse (LPN) #3 was observed to administer Novolog insulin 12 units via an insulin pen to a resident. The LPN did not prime the pen needle prior to administration. On 7/27/22 at 5:56 p.m. LPN #3 was observed administering 15 units of insulin Lispro via an insulin pen to a resident. The LPN did not prime the pen needle prior to administration. The LPN was interviewed at this time, and she said she did not prime the insulin pen needles prior to administering insulin pens. IV. Additional interviews LPN #4 was interviewed on 7/28/22 at 8:48 a.m. He said the proper way to use an insulin pen was to first wipe the top off with an alcohol prep pad, then screw on the needle and prime the pen to get the bubbles out. He said he was taught to prime the pen in nursing school, not something specific from the facility. The NHA, a registered nurse, and the director of nursing in training (DON) were interviewed on 7/28/22 at 6:18 p.m. They said agency staff upon first hire shadowed a nurse at the facility to get oriented and that should include insulin administration with insulin pens. They said insulin pens were to be primed with two units of insulin prior to administering the dose to a resident.

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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. 40840 Based on observations, record review and interviews, the facility failed to ensure proper storage of pharmaceuticals for one of one medication storage rooms. Specifically, the facility failed to ensure proper temperatures for refrigerated pharmaceuticals. Findings include: I. Facility policy and procedure The Medication and Vaccine Refrigerator/Freezer Temperatures policy, revised 11/15/2020, provided by the NHA on 7/28/22 at 12:00 p.m. read in pertinent part, refrigerators and freezers used to store medication and vaccines will operate within acceptable temperatures ranges and will be checked twice a day for proper temperatures. The acceptable refrigerator temperature range for meditation and vaccine storage is 36-46 degrees fahrenheit. II. Observations The facility medication storage room was inspected with licensed practical nurse (LPN) #1 on 7/27/22 at 5:00 p.m. The medication storage refrigerator internal temperature was observed to be 26.2 degrees fahrenheit and this was confirmed with the LPN, which was not within the acceptable refrigerator range of 36-46 degrees fahrenheit. Inside the refrigerator the following medications/vaccine were stored: -Aplisol tuberculin -Prevnar 13 -Hepatitis B Vaccine -Shingles Vaccine -Insulin Lispro -Humilin R (insulin) -Insulin Glargine -Lorazepam solution III. Record review (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's refrigerator log for July 2022 was reviewed. The log did not indicate a range of appropriate temps for the refrigerator and was only checked once a day by staff. The following dates indicated a temperature outside of 36-46 degrees fahrenheit: -7/1/22: 33.1 degrees fahrenheit -7/2/22: 34.8 degrees fahrenheit -7/3/22: 31.8 degrees fahrenheit -7/5/22: 34.5 degrees fahrenheit -7/10/22: no temperature recorded -7/11/22: 33.9 degrees fahrenheit -7/13/22: 30.8 degrees fahrenheit -7/14/22: 31.7 degrees fahrenheit -7/16/22: 31.7 degrees fahrenheit -7/17/22: 34.2 degrees fahrenheit -7/19/22: 22.1 degrees fahrenheit -7/20/22: 21.3 degrees fahrenheit -7/21/22: no temperature recorded -7/23/22: 34.26 degrees fahrenheit -7/26/22: 32.36 degrees fahrenheit -7/27/22: 34.1 degrees fahrenheit Manufacturer storage instructions for some of the medications stored in the refrigerator indicated: Manufacturer storage instructions for Aplisol tuberculin provided by the facility read, DO NOT FREEZE. This product should be stored between 36-46 degrees fahrenheit. Manufacturer storage instructions for Lorazepam oral concentrate provided by the facility read, Store at cold temperature-refrigerate between 36-46 degrees fahrenheit IV. Interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 7/27/22 at 5:00 p.m. She said the facility management had told her the staff were supposed to be monitoring the refrigerator temperature and directed her to make the temperature log sheet. She said she was never told the correct temperature range, and that was why it was not on the log sheet. She said she generally tried to keep the temperature range between 32 and 38 degrees fahrenheit. The NHA, a registered nurse, and the director of nursing in training (DON) were interviewed on 7/28/22 at 6:18 p.m. The NHA said the temperatures were checked nightly and if out of range the staff were to adjust the refrigerator and mediations inside the refrigerator would be discarded. She said the temperatures should be kept per the manufacturer instructions, which was generally 36-46 degrees fahrenheit. She said staff should be recording the temperature on the log on the refrigerator and the temperature range should be on that log and it would be added.

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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. 42193 Based on observations,interviews and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures. Specifically, the facility failed to ensure that residents' food was papatable in taste, texture, appearance and temperature. Findings include: I.Facility policy and procedure The Food and Nutrition Service policy, revised 7/15/18, was delivered by the nursing home administrator (NHA) on 7/1/22 at 12:32 p.m. It read in pertinent part: Critical food functions are continuously measured as part of the quality improvement program. Food service quality includes meal delivery, meal quality, meal accuracy and meal satisfaction.The director of the dining service is responsible for communicating department quality indicators to the executive director, quality assurance and registered dietitian. Meal quality standards:foods are held at appropriate holding temperatures, Foods have an acceptable taste and are of appropriate texture for the food or for the diet modification. All meals are attractively garnished. Meal/Tray is complete and served according to the menu and food preferences.Foods are prepared, held, and served in a safe and sanitary manner. II. Resident council A group of six residents were interviewed on 7/27/22 at 3:00 p.m. The residents said they had concerns about the food. The comments made were the meat could be tough, the vegetables over cooked and there was not enough flavor in the food. The group said they were aware there was a new dining services director, however, there has not been enough improvement in the food. The group also said the kitchen ran out of brown sugar for almost a month. III. Observation The tray line was observed on 7/27/22 beginning at 4:52 p.m. The plates were warm, and the room trays were placed with a cover, however, there was no heating element on the plate to ensure the food would stay hot as it was transported to the unit. The temperatures on the tray line were: -Baked fish 180 F (degrees fahrenheit) -Zucchini- 190 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A test tray, regular diet was evaluated immediately after the last resident had been served on the 400 hallway on 7/27/22 at 6:18 p.m. The baked fish looked mushy and a slice of bread was added to the top of the top of the fish which was soggy.The vegetables tasted bland with no flavor and were cool to the palate with a temperature of 118 F. The potatoes tasted bland with no butter flavor. The fish was 118 F and soggy to taste.The zucchini were mushy with no flavor and no taste of butter or other seasoning. There was no lemon or parsley garnish on the plate as listed on the menu. IV. Resident interviews All residents were identified by facility and assessment as interviewable. Resident #35 was interviewed on 7/26/22 at 9:15 a.m. The resident said the food needed help. He said that the food did not look good and it had no flavor. Resident #24 was interviewed on 7/26/22 at 9:30 a.m. The resident said the kitchen ran out of food and had run out of brown sugar. The resident said the food needed to have more flavor as it was bland in taste. Resident #56 was interviewed on 7/26/22 at 9:30 a.m. The resident said the food was not good. She said they did not serve past any longer. She said that she did not always get what she ordered. V. Staff interviews The dining service director (DSD) was interviewed on 7/28/22 at 4:35 p.m. He said that the corporate office has approved him to get a new plate warmer for the kitchen. He said the residents got mad at him because of the food being late to the units and also the food was cold. He said the residents complained to him that they did not get what they ordered. He said he was going to implement a different way of taking orders from the residents. He agreed the fish from the supper meal on 7/27/22 was soggy and the vegetables were mushy. He said he was sure the cook had seasoned the food. He indicated he would pay closer attention to this next time. VI. Record review Monthly food committee notes dated 6/14/22. Three residents were in attendance.This was the first food committee meeting held at the facility since the DSD started working at the facility.The second meeting was to be held on 7/29/22. It documented comments from residents which were the food's appearance could be better, the food looks sloppy on the plate and the food should come to the units faster and then it would not be cold. 20287 40840 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46851

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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 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** 40840 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection, including COVID-19 for three of four units. Specifically, the facility failed to: -Ensure equipment and supplies were disinfected between resident uses; -Ensure residents were offered hand hygiene before meals in both the dining rooms and room trays; -Ensure personal protective equipment were worn properly; and, -Ensure proper disposal of medication syringes. Findings include: I. Cleaning equipment A. Professional reference According to the Centers for Disease Control and Prevention (last reviewed 5/24/2019) Disinfection of Healthcare Equipment, retrieved 8/4/22 from https://www.cdc.gov/infectioncontrol/guidelines/disinfection/healthcare-equipment.html, read in part, Medical equipment surfaces (e.g., blood pressure cuffs, stethoscopes, hemodialysis machines, and X-ray machines) can become contaminated with infectious agents and contribute to the spread of healthcare-associated infections. For this reason, noncritical medical equipment surfaces should be disinfected with an EPA-registered low- or intermediate-level disinfectant. Use of a disinfectant will provide antimicrobial activity that is likely to be achieved with minimal additional cost or work. B. Observations On 7/27/22 at 10:35 a.m., the activity assistant (AA) was observed to enter three separate resident rooms with a beach ball. She then proceeded to hit the beach ball back and forth with residents. She failed to clean the ball between residents. On 7/26/22 at 4:31 p.m., certified nurse aide (CNA) #8 was observed to take vital signs for the resident in 208A. He placed the blood pressure cuff, and the pulse ox on his finger. After he completed the vitals, he then rolled up the cuff and placed it into the basket with the pulse ox. He did not clean the equipment. He was then observed to cross the hallway and completed the vitals on the resident in room [ROOM NUMBER]B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/27/22 at 11:50 a.m. CNA #5 and CNA #7 assisted a resident in 209B with the sit-to-stand lift. The resident held onto the grab bar, and the CNAs maneuvered the lift with gloved hands as they assisted the resident. However, when completed, the sit-to-stand lift was placed back where it was stored for next use, without being cleaned. C. Interviews The AA was interviewed on 7/27/22 at 11:30 a.m. The AA confirmed that she did not disinfect the beach ball in between each resident. She said that usually she would use a balloon but today used the beach ball. She said it was on the calendar to go room to room and to play volleyball with the residents. She said she did not know she had to clean the ball between residents. The director of nurses was interviewed on 7/28/22 at 2:21 p.m. The DON said all equipment needed to be disinfected with the micro Kill wipes. She said the staff had been trained to clean the equipment between uses. II. Failure to ensure residents were offered hand hygiene before meals A. Professional reference The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (updated 2/2/22), retrieved on 8/1/22 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, read in pertinent part, Educate residents and families through educational sessions and written materials on topics, including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones from SARS-CoV-2, and actions they should take to protect themselves and others in the facility, emphasizing when they should wear source control, physically distance, and perform hand hygiene.Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. B. Facility policy The Hand Hygiene policy, effective 12/1/06, provided by the DON on 7/28/22 at 6:13 p.m. read in pertinent part, adherence to hand hygiene practices was maintained by all residential care facility personnel. This included washing with soap and water when hands are visibly soiled and the use of alcohol based hand rubs for routine decontamination in clinical situations. Decontaminate hands using an alcohol based hand rub or wash hands with antimicrobial soap and water in the following situations: -Before any direct contact with a resident -Before putting on gloves -Before inserting catheter, vascular access or other invasive devices -After contact with a residents intact skin (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings. -When moving from contaminated body site to clean body site during resident care -After contact with an inanimate object in the immediate vicinity of the resident -after removing gloves. C. Observations 7/27/22 -At 12:41 p.m., CNA #2 was observed to pass a room tray to 204A. She set the resident up and raised his bed. She did not offer hand hygiene to the resident prior to leaving the room. CNA #2 failed to perform hand hygiene when she left the room and before she took another tray from the food cart. -At 12:43 p.m., CNA #5 was observed to pass a room tray to 206A. She moved the bedside table, and relocated personal items from the table. She proceeded to set the meal tray up. She did not offer hand hygiene to the resident prior to leaving the room. She failed to perform hand hygiene when she left the room and prior to retrieving another tray from the food cart. -At 12:45 p.m., the business office manager (BOM) passed a tray to a resident in room [ROOM NUMBER]. She did not offer hand hygiene to the resident prior to the meal. -At approximately 12:45 p.m., the activities director passed a room tray to the resident in 208 bed one. The AD failed to offer hand hygiene to the resident prior to the meal. D. Interviews The BOM was interviewed on 7/27/22 at 12:50 p.m. The BOM said she was newly employed and that she assisted to pass resident room trays usually at the noon meal. She said she had not gone through any training and was not educated to offer hand hygiene to the residents prior to their meal. The AD was interviewed on 7/27/22 at approximately 12:50 p.m. The AD said she passed out resident trays regularly. She did confirm she did not offer hand washing. She said she had been trained on the importance of offering hand hygiene, but somehow she did not remember. She said she would offer from now on. The DON was interviewed on 7/28/22 at 2:21 p.m. The DON said residents needed to be offered hand hygiene with either a packaged hand cleaning cloth, or other means, such as soap and water. She said the staff had been trained on the importance of offering hand hygiene. III. Mask use A. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The personal protective equipment (PPE) guide for healthcare personnel, dated 5/3/22, provided by the DON on 7/28/22 at 2:45 p.m. read in part, Source control referred to the use of respirator or well fitting masks or cloth masks to cover a person mouth and nose to prevent the spread of respiratory secretions when they are breathing, talkin, sneezing, or coughing. Source control and physical distancing are recommended for everyone in a healthcare setting. This was particularly important for individuals regardless of their vaccination status who live or work in counties with substantial to high community transmission. B. Observations On 7/25/22 at 3:35 p.m. an unknown staff member was observed exiting resident room [ROOM NUMBER]B with garbage bags and her mask down below her chin. On 7/25/22 at 5:30 p.m. an unknown staff member was observed on the kitchen line serving food while over the counter with her mask pulled down below her chin. On 7/28/22 at 12:28 p.m., a visitor was speaking with licensed practical nurse (LPN) #2 on the 200 hallway. The visitor had her face mask below her chin. LPN #2 did not tell the visitor to pull her mask up. C. Interview The DON was interviewed on 7/28/22 at 2:21 p.m. The DON said staff including visitors should wear face masks at all times and properly, which included, covering the nose and the mouth while in the facility. IV. Disposal of sharps/syringes A. Professional reference According to the CDC Safe and Proper Sharps Disposal During the COVID-19 Mass Vaccination Campaign (last reviewed 8/17/21), obtained on 8/4/21 from https://www.cdc.gov/vaccines/covid-19/training-education/safe-proper-sharps-disposal.html#:~:text=Best%20practice%20is%20to%20immediately,or%20other%20potentially%20infectious%20material. -Do not remove, recap, break, or bend contaminated needles or separate contaminated needles from syringes before discarding them into a sharps disposal container as this increases the risk of a needlestick injury and a bloodborne pathogen exposure. Best practice is to immediately place the connected needle and syringe into the sharps disposal container. -Use sharps containers to dispose of needles and other sharps contaminated with blood or other potentially infectious material. B. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/22 at 8:45 a.m., a family member was observed exiting resident's room [ROOM NUMBER], who was on transmission based precautions, holding a used syringe while saying it was left on the bedside table. C. Interview The DON was interviewed on 7/28/22 at 2:21 p.m. She said syringes should be disposed of in the sharps container in the resident room, and she had already provided education to the staff member who was identified to have left the syringe on proper disposal. 46851

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40840 Based on interviews and record review, the facility failed to have a qualified infection preventionist on staff. Specifically, the facility failed to have a qualified infection preventionist on staff. Findings include: I. Facility policy and procedure The Infection Prevention and Control Program (IPCP) Description policy, revised 6/7/21, was provided by the health information manager (HIM) on 7/28/22 at 5:00 p.m. It read, Design and Role Responsibilities the IPCP was facilitated through a coordinated effort between the designated infection preventionist, center executive director, center nurse executive, and nurse practice educator/staff development coordinator, and the entire health care team. The infection preventionist develops, implements, and monitors and maintains the IPCP and fulfills the basic requirement for the role. II. Interviews The director of nursing (DON) and interim assistant director of nursing (IADON) were interviewed on 7/28/22 at 2:21 p.m. They said neither of them had completed the Nursing Home Infection Preventionist Training course provided by the Centers for Disease Control and Prevention (CDC). The IADON said he was newly employed and he was currently working on the course and was part way through. He said he had recently been put into the IP role and was putting together many ideas for his new responsibilities. The DON said currently there was no one certified in the role of IP for the facility.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40840 Based on interviews and record review, the facility failed to test facility staff, and individuals providing services under arrangement and volunteers for COVID-19 which had the potential to affect all 69 residents residing in the facility at the time of the survey. Specifically, the facility failed to complete weekly lab based PCR (polymerase chain reaction) testing for COVID-19, and rapid molecular or antigen test consistently prior to the start of their shift, based on the facility's county positivity rate. Findings include: I. Professional reference The healthcare community transmission levels for the facility ' s county of residence, obtained from https://covid19.colorado. gov/healthcare-providers/long-term-care-facilities/healthcare-community-transmission-levels, were reviewed for the time of survey (7/25-7/28/22) and found to be in High levels of transmission. Facilities should use their community transmission level as the trigger for staff testing frequency https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858 In nursing homes, HCP (health care personal) who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week. If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift). II. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 7/28/22 at 11:24 a.m. He said he had the first original vaccines but no booster. He said they only tested if there was an exposure or incident, but there was no weekly testing. The dietary service director (DSD) was interviewed on 7/28/22 at 11:28 a.m. He said he had the single dose Johnson & Johnson vaccine and no booster. He said he was scheduling himself to get the booster. He said he was testing twice a week on Tuesday and Friday. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensed practical nurse (LPN) #2 was interviewed on 7/28/22 at 11:30 a.m. LPN #2 said she was not up to date on her vaccination. She said that she had not received the booster and had not been encouraged. She said she had not tested prior to her shift. She said she was supposed to be tested twice weekly with a PCR, but was not always. Unit manager (UM) #1 was interviewed on 7/28/22 at 11:33 a.m. She said she had the original two vaccination series and no booster. She said she was testing twice a week on Tuesday and Friday. The health information manager (HIM) was interviewed on 7/28/22 at 11:40 a.m. The HIM said she was not up to date on her vaccination. She said she received two doses, but had refused to get the third dose. She said she did not test daily prior to her shift. III. COVID testing The healthcare community transmission rate was high beginning on 7/25/22 when the survey began. According to the resident comprehensive mitigation plan, the staff who were not up to date on their vaccinations needed to complete a rapid POC test prior to their shift. The POC testing reviewed for time of survey showed no staff were performing POC tests until 7/28/22. The staff who were not up to date on vaccinations along with testing prior to the shift, must also complete a Lab based PCR (polymerase chain reaction) twice a week. Review of the PCR records showed not all staff who were not up to date on their vaccinations did not test twice a week with a PCR. For example: -Certified nurse aide (CNA) #2 provided by the facility showed the staff member was last tested on [DATE], which was 12 days prior to the survey start. Lab based testing for UM #1 provided by the facility showed that the staff member was last tested on [DATE], which was 12 days prior to the survey start. There were no POC testing documentation for LPN #4 or the DSD for the time of survey (7/25-7/28/22). IV. Nursing leadership interview (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The director of nursing (DON) and interim assistant director of nursing (IADON) were interviewed on 7/28/22 at 2:21 p.m. The DON said if the facility were in an outbreak the not up to date staff would be performing POC testing prior to start of shift daily. They said currently they were not performing routing POC testing. They said only non up to date staff were performing the lab based testing as well. The DON said she was unaware the staff who were not up to date on vaccinations were to perform a POC test prior to their shift. They said they had not been checking the county transmission rates, but they would be checking it daily now. They said they should have been doing POC testing daily for not up to date staff and lab based testing twice a week and have not been doing that.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 40840 Based on observations, record review and interviews, the facility failed to develop and implement a COVID-19 staff vaccination process to address all facility staff, including agency staff who provided care, treatment and other services to facility and/or residents. Specifically, the facility failed to obtain the vaccination status of other outside providers. The facility did not have the vaccination status for all of the outside providers. The facility was unable to provide a listing of the vaccination status of all contracted providers/staff who enter the facility on a regular basis and provide direct care to residents. Cross-reference F886 (COVID-19 testing) Findings include: I. Facility policy and procedure The Universal COVID-19 Vaccination policy, revised 4/1/22, provided by the nursing home administrator (NHA) on 7/28/22 at 12:00 a.m. read in pertinent part The company requires that all personnel are fully immunized against COVID-19 as follows. All center based personnel or national, market, or divisional personnel who regularly work in or visit centers or company offices, and all office based personnel who regularly, routinely, or intermittently work in and or visit company offices and all company leaders at the level of vice president or above. All personnel will be fully vaccinated against COVID-19 and obtain any necessary booster immunization when and if the booster are required and/or are necessary. Students, members of medical staff, volunteers, care partners, non-employed caregivers, physicians/advanced practice providers, intermittent providers, and contracted personnel must provide proof of vaccination. The nursing home administrator was provided a request for a matrix for all staff and outside providers and volunteers on 7/25/22 at approximately 8:30 a.m. A second request for the record of immunizations for outside and contracted providers was requested on 7/26/22 at 3:00 p.m. The interim assistant director of nursing (IADON) said he would have to figure out where that information was and get back. It was not provided until 7/28/22 at 6:00 p.m. The interim assistant director of nursing (IADON) was interviewed on 7/26/22 at approximately 4:00 p.m. The IADON said he was currently working on obtaining the vaccination status of other outside providers. He said the facility did not have the vaccination status for all of the outside providers. II. Record review Staff vaccination histories were provided by the facility. The vaccination histories failed to ensure all staff were up to date on their vaccination status. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dietary service director: documentation showed no response for any doses and waiting for vaccine card. -Review of the matrix provided by the facility failed to include the medical providers, which included, primary physicians, hospice and other professionals. III. Interviews The director of nursing (DON) and interim assistant director of nursing (IADON) were interviewed on 7/28/22 at 2:21 p.m. They said they were new to the roles they were in and they were working on developing a staff tracking system for staff and outside providers. The IADON said he was recently put into the role two weeks ago for the infection preventionist (IP). The IADON said he was unsure of the current numbers of staff who were not up to date, as he said there were some refusals, but he would be working on a line tracking system to keep current information of staff/providers vaccination status. IV. Facility COVID-19 status The facility COVID-19 line listing as of 7/27/22 showed the facility had no confirmed positive cases of COVID-19 in either resident or staff members. The facility had one presumptive resident as of 7/28/22.