STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065146	A. Building B. Wing	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampden Hills Post Acute	14699 E Hampden Ave Aurora, CO 80014

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33298 Based on record review, observations, and interviews, the facility failed to ensure that two (#5 and #6) out of 11 sample residents received care and services to prevent the development and worsening of pressure injuries. Resident #5 was dependent on staff for mobility, transfers and repositioning and was identified at risk for developing pressure injuries. The facility failed to prevent the development and worsening of a pressure injury for Resident #5. On 11/18/21 an unstageable pressure injury was discovered on Resident #5's coccyx. The facility failed to implement wound care orders until 11/20/21, two days after discovery, and failed to implement an air mattress until 11/25/21, seven days after discovery. The resident was noted to be resistant to care with minimal documentation done in response to the resident's resistance including a comprehensive assessment by the interdisciplinary team. Wound care treatment orders were not consistently followed. Due to the facility's failures, the resident developed an avoidable, facility acquired unstageable pressure wound to her coccyx. The resident was transferred to the hospital on 1/7/22 where she was discovered to have sacro-coccygeal (coccyx area) osteomyelitis (bone infection) which required intravenous antibiotics. Resident #6 had diagnoses of spinal stenosis, muscle wasting/atrophy, and protein calorie deficiency and was identified as being at risk for developing pressure injuries. Based on the initial MDS assessment 9/29/21, the resident was at risk for developing pressure ulcers but had no unhealed pressure ulcers. A nurse's note dated 9/30/21 indicated the resident had a darkened area to the right heel. The facility failed to consistently monitor the right heel after the 9/30/21 nurse's note that indicated he had a darkened area to his right heel. In addition, he had moisture associated skin damage to his coccyx on 11/21/21. On 1/18/22, it was documented the coccyx wound was resolved per the wound doctor. Due to the inconsistencies in monitoring of his skin to include pressure injuries, he developed an unstageable right heel wound on 12/5/21 and unstageable coccyx wound on 1/25/22 as indicated in the wound doctor's notes. Furthermore, the facility failed to provide wound care treatments consistent with professional standards of practice, to an existing pressure ulcer to promote wound healing, prevent worsening of the wound, and prevent potential cross contamination during wound care services for Resident #6 (Cross-reference F880, infection control practices). Moreover, the facility failed to identify and report a new area to the Resident #6's left hip and failed to obtain a physician's order to treat the wound. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Professional reference The National Pressure Ulcer Advisory Panel (2016) NPUAP Pressure Injury Stages, retrieved on 2/8/22 from: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf revealed the following pertinent information: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin 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. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). 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. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. 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. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. 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 is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	II. Facility policy and procedure The Pressure Ulcer Prevention Program policy, revised 10/8/2020, was provided by the assistant nursing home administrator (ANHA) on 2/1/22 at 4:47 p.m. It read, in pertinent part: All residents will be assessed for the risk of pressure ulcer development at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to prevent the development of avoidable pressure ulcers, or, to treat existing pressure ulcers. All residents will be screened for risk of pressure ulcer development utilizing the braden scale. This will be done at the time of admission/readmission, for 4 weeks thereafter, then quarterly and upon significant change in condition. Residents identified as being at risk will have interventions identified in their plan of care to prevent the occurrence of pressure ulcers. All residents will have a head to toe assessment completed on a weekly basis by a licensed nurse to identify any skin breakdown. The results of this assessment will be documented in the resident's medical record. If a pressure ulcer or skin breakdown is identified, the following will be done: -The licensed nurse will complete a thorough assessment of the affected area. The assessment must include size, stage, location, drainage, and color. -The licensed nurse will notify the physician and family. -Treatment will be initiated per physician orders. -The resident's plan of care will be updated to reflect interventions. -The interdisciplinary team will be notified so that appropriate referrals may made to the dietician, therapy, etc. -The licensed nurse will assess the area on a weekly basis to determine progress and modify treatment as appropriate. The DON (director of nursing) or designee will track and monitor pressure ulcers weekly. In the event the primary assessing nurse is not by state practice act allowed to stage a pressure ulcer, then the DON/RN (registered nurse) must view and stage the pressure ulcer weekly. The DON/designee will report results to the quality assurance improvement committee on a quarterly basis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer Prevention and Treatment Toolkit, revised July 2018, was provided by the assistant nursing home administrator (ANHA) on 2/1/22 at 4:47 p.m. It read, in pertinent part: This toolkit is intended to assist the resident's care team in assessing, developing the plan of care, monitoring the plan implementation and effectiveness, and revising the plan of care, as indicated, to meet the individual resident's needs. -Skin assessment: Regularly conduct thorough skin assessment on each resident who is at risk of developing pressure ulcers. Such skin assessments allow early detection of developing or existing skin breakdown or to verify the integrity of the skin. The assessments help to identify the ability of the skin and underlying tissue to maintain integrity with reduction or redistribution of pressure (tissue tolerance) and assist in the development of prevention strategies. -When conducting skin assessments evaluate all areas at risk of constant pressure, with consideration of various areas that may be affected during the resident's daily activities related to: positioning in bed; positioning in chair with risks from slouching or sliding; use of medical devices; and presence of contractures or deformities. -Repositioning: Repositioning should occur at least every 2 hours, but more frequent repositioning may be warranted for individuals who are at higher risk for pressure ulcer development or who show evidence that repositioning at 2-hour intervals is inadequate. II. Resident #5 A. Resident status Resident #5, age 77, was admitted on [DATE] and discharged to the hospital 1/7/22. According to the January 2022 computerized physician orders (CPO), the diagnoses included bilateral primary osteoarthritis of knee, morbid obesity, cardiac arrest, chronic obstructive pulmonary disease (COPD) with acute exacerbation, respiratory failure, pressure ulcer of sacral region unstageable (added 12/1/21), unspecified severe protein calorie malnutrition, other dysphagia, dementia without behavioral disturbance, and unspecified heart failure. The 12/1/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of six out of 15. Rejection of care was not coded to be exhibited. She was totally dependent on staff for mobility, transfers, and activities of daily living (ADLs) and required extensive assistance of one staff member for eating and personal hygiene. She had an indwelling catheter, was always incontinent of bowel and did not have constipation. She received 51% or more of her nutrition and hydration through a feeding tube. She had an unstageable pressure injury that was not present on admission. She had a pressure reducing device for her bed and her chair and was on a turning and repositioning program. B. Record review Braden scale assessments completed weekly upon admission on 8/3/21, 8/10/21, 8/17/21, and 8/24/21 revealed the resident was at risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A new wheelchair with a gel cushion for wheelchair and recliner was provided by physical therapy on 8/30/21 due to resident's reluctance to transfer and change positions outside of therapy activities. The resident's ADL documentation from 8/3/21 to 1/7/22 when she discharged to the hospital was reviewed and revealed the resident received ADL services multiple times a day including but not limited to turning and repositioning, bowel management, catheter care, transferring, personal hygiene, and bed mobility. Turning and repositioning services were frequently refused by the resident. In September 2021 a bed mobility and active range of motion program was added for the resident twice a day three times a week to increase her movement and independence. These tasks were documented as completed or attempted with multiple resident refusals. A range of motion and bed mobility program care plan dated 8/31/21 read Resident to participate in range of motion and bed mobility program 3 x per week related to muscle weakness. The goal of the care plan read: Resident will be able to roll with assist of mod-max and verbal cueing techniques. Ensure resident can participate in ADL care, pressure redistribution, and proper body alignment. An ADL care plan revised on 12/16/21 read: Resident has an ADL self care performance deficit related to respiratory failure, history of cardiac arrest, dementia, atrial fibrillation, tremors, vitamin D deficiency, heart failure, hypothyroidism, diabetes mellitus II, anemia, and osteoarthritis. An actual skin impairment care plan dated 11/19/21 read: The resident has actual impairment to skin integrity of the coccyx related to suspected deep tissue injury. Interventions included: Follow treatment order per physician order; Notify physician of any signs or symptoms of infection; Pressure reducing mattress to protect the skin while in bed; and Resident will be seen by wound doctor in the facility. A skin care plan dated 12/2/21 read: Resident has a pressure ulcer on coccyx, unstageable due to slough. The goal read: The pressure ulcer will show signs of healing and remain free from infection. Interventions included: Administer medications as ordered; Administer treatments as ordered and monitor for effectiveness; Apply lotion to dry skin prn (as needed); Assess/record/monitor wound healing with weekly wound rounds. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (medical doctor); Barrier cream with incontinence care as needed; Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility; good nutrition and frequent repositioning; Follow facility policies/protocols for the prevention and treatment of skin breakdown; If the resident refuses treatment, confer with the resident, IDT (interdisciplinary team), and family to determine why and try alternative methods to gain compliance. Document alternative methods; Inform the resident, family and caregivers of any new areas of skin breakdown; Instruct and assist to shift weight in wheelchair as tolerated; low air loss mattress for pressure re-distribution; monitor dressing to ensure it is intact and adhering. Report lose dressing to treatment nurse; monitor nutritional status. Serve diet as ordered, monitor intake and record; Teach resident and family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes; The resident needs to turn and reposition as needed per protocol or requested; Treat pain as per orders prior to treatment and turning to ensure resident's comfort. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The care plan did not indicate the resident refused to be repositioned or turned. Review of the resident's wound progress, therapy and nutrition notes revealed the resident was educated to the importance of repositioning, nutrition and participation in therapy for wound healing. The notes revealed the resident's family was informed of her condition and refusals, though there was no specific evidence of educating the family related to the risks or attempts to involve family to motivate the resident. A weekly body check dated 11/13/21 revealed the resident had no skin issues. An incident report dated 11/18/21 revealed the nurse was notified by the certified nurse aide (CNA) while changing the resident an open area on the coccyx was discovered. The wound nurse was notified and came to measure the wound 3 cm (centimeters) x 2 cm x .3 cm. The wound was cleaned with normal saline and covered with a dry protective dressing. The nurse practitioner was notified and a message was left for the resident's power of attorney. The unit manager and director of nursing were notified. The resident was educated to stay in bed and reposition as tolerated. -The incident report did not document whether muscle was exposed, slough was present or drainage noted. In addition, there was no stage of the pressure wound indicated on the incident report. A wound care order was entered onto the resident's treatment administration record (TAR) and read: Wound Care: Clean coccyx wound with normal saline, pat dry and apply skin prep peri-wound. Apply wet-to-dry and cover with foam dressing BID (twice daily) and as needed until the wound team evaluate and change dressing order on Monday, 11/22/2021, two times a day for Wound Care/skin integrity. Ordered on 11/20/21. -The wound care order was not added to the resident's TAR until two days after the wound was discovered on 11/18/21. A nutrition note dated 11/19/21 revealed the resident had a new wound on her coccyx and was encouraged to lie down and offload, however, the resident preferred to stay in her lounge chair versus lie down. (The registered dietitian) Recommended increase in nocturnal enteral nutrition (supplemental nutrition given via a feeding tube) by 180 ml (milliliters) to provide an additional 216 kcals, 10.8 g protein, and 144.9 ml of water and extend the run time to continue volume rate. Glucerna 1.2 (formula) at 60 ml/hour x 12 hours on at 5:00 p.m. and off at 5:00 a.m. via gtube (gastrostomy tube). Provides 720 ml enteral nutrition per day, 864 kcals (calories) per day, 43.2 g (grams) protein per day and 579.6 ml water. The updated estimated needs related to the new wound were approximately 1697-2007 kcal per day and protein 63 to 75 grams per day. The resident was reassessed by physical therapy on 11/20/21 due to the skin breakdown. A new NYOrtho (pressure reducing cushion) wheelchair cushion with gel insert was provided for the resident's wheelchair and recliner. A new tube feeding order was started on 11/22/21 for Glucerna 1.2 at 60 ml/hour for 9 hours (on at 5:00 p.m. and off at 5:00 a.m.) via g-tube. Provides 540 mL EN (enteral nutrition)/day,~ (estimated) 648 kcal/day, ~32.4 g PRO (protein)/day, and ~434.7 mL water/day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Review of this order revealed the order was incorrectly worded where the run time was 12 hours but the order read nine hours. The medication administration record revealed the order was completed daily, though was written incorrectly. The resident was seen by the wound care physician during rounds on 11/22/21. The notes revealed the coccyx wound was an unstageable pressure injury obscured full thickness skin and tissue loss. Initial encounter measurements were 4 cm x 4 cm with no measurable depth. Muscle was exposed and the resident reported no pain. The wound bed was 75% slough and 25% granulation. The skin texture, moisture, and color were normal. A debridement was performed where muscle and subcutaneous tissue were removed along with slough. The resident reported no pain during the procedure. Post debridement measurements were 4 cm x 4 cm x .3 cm. Wound treatment orders were written to apply Dakin's gauze and cover with a foam dressing twice daily. Healing was expected to be delayed due to inevitable effects of aging. -However, the initial measurements obtained 11/18/21 on the incident report the wound measured 3 cm x 2 cm x .3 cm. There was an increase in size from the initial measurements. There was no comprehensive assessment by the IDT with the increase in wound size. A wound care order was entered on 11/22/21 to 12/16/21 which read: Wound Care: Clean coccyx wound with normal saline, pat dry and apply Dakin's Solution 0.25% on gauze then pack the wound with gauze the one soaked in dakin's solution and cover with Foam dressing BID (twice daily) and as needed, two times a day for Wound Care/skin integrity. -Review of the treatment administration record revealed the resident refused the wound treatment on the evening shift on 11/24/21 and the wound treatment was not completed on 11/26/21 or 11/27/21 on the evening shift though it was completed on the morning shift both days (11/26/21 and 11/27/21). An order for a low air loss mattress to the resident's bed was received on 11/25/21. -The order for the low air loss mattress was seven days after the wound was discovered. The resident was dependent on staff for mobility, transfers and repositioning. The resident was seen by the wound care physician during rounds on 11/29/21. The notes revealed the coccyx wound was an unstageable pressure injury obscured full thickness skin and tissue loss. Measurements were 4 cm x 4 cm with no measurable depth. Muscle was exposed and the resident reported no pain. The wound bed was 80% slough and 20% granulation. The skin texture, moisture, and color were normal. No signs or symptoms of infection. The wound was improving. A debridement was performed where muscle and subcutaneous tissue were removed along with slough. The resident reported no pain during the procedure. Post debridement measurements were 4 cm x 4 cm x .3 cm. Wound treatment orders were written to clean the wound with normal saline, apply Dakin's gauze and cover with an ABD (abdominal gauze) pad twice daily. Healing was expected to be delayed due to inevitable effects of aging. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nutrition note dated 12/1/21 revealed the resident was being reviewed for a significant change due to recent unstageable pressure injury. Tube feeding was increased on 11/22/21 to meet increased needs due to continued varied oral intake. Physician assistant ordered a registered dietician consult to review oral intake for desired tube feeding wean. However resident's oral intake remains poor and declines to work with speech therapy for advancement. Decrease in tube feeding is not recommended at this time related to increased demand for wound healing. Spoke to resident, noted was only taking bites of cake. Juice and lunch untouched. Educated regarding increased needs to heal wound. Educated for goal to eat 50% of meals in order to reduce the need for tube feedings. Resident stated she did not want to talk about it. Re-emphasized the importance of intake for healing. Resident still drinking oral glucerna. Clarified with nurse tube feeding was running 12 hours for nocturnal feeding. -The enteral feeding order (see above) was corrected on 11/30/21 to reflect the run time of 12 hours. A nursing note dated 12/3/21 revealed the resident refused to be repositioned. The resident was educated related to the importance of repositioning for wound healing. The resident verbalized understanding but still did not allow staff to reposition her. The resident was seen by the wound care physician during rounds on 12/6/21. The notes revealed the coccyx wound was an unstageable pressure injury obscured full thickness skin and tissue loss. Measurements were 5 cm x 5 cm with no measurable depth. Muscle was exposed and the resident reported no pain. Undermining was noted at 12:00 and ending at 12:00 with a maximum distance of 2 cm. The wound bed was 90% slough and 10% epithelialization. The skin texture, moisture, and color were normal. No signs or symptoms of infection. There was no change noted in the wound progression. A debridement was performed where muscle and subcutaneous tissue were removed along with slough. The resident reported no pain during the procedure. Post debridement measurements were 5 cm x 5 cm x .3 cm. Wound treatment orders remained the same to clean the wound with normal saline, apply Dakin's gauze and cover with an ABD pad twice daily. Healing was expected to be delayed due to inevitable effects of aging. -Despite objective worsening of the wound with a larger measured size, undermining, and greater percentage of slough, the wound treatment orders were not changed. In addition, there was no comprehensive assessment by the IDT. -Review of the resident's December 2021 TAR revealed wound care was not provided on 12/2/21 on the evening shift. A nutrition note dated 12/6/21 revealed the RD spoke to the resident who was in bed with her lunch tray set up. She was noted to eat a few bites of mashed potatoes and meat and took sips of glucerna. The RD encouraged more intake. The resident agreed to try to eat more but did not take another bite during the visit. Discussed may need to try an additional protein supplement for wound healing. Resident continued to decline to eat more. Recommended 30 ml active protein liquid or equivalent twice a day for wound healing. An order was added on 12/6/21 to 12/29/21: Prostat two times a day 30 mL Active Protein Liquid or equivalent BID for wound healing. Attempt PO (oral intake). -Review of the resident's December 2021 MAR revealed the order was completed twice a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident was seen by the wound care physician during rounds on 12/16/21. The notes revealed the coccyx wound was an unstageable pressure injury obscured full thickness skin and tissue loss. Measurements were 4.5 cm x 5 cm with no measurable depth. Muscle was exposed and the resident reported no pain. The wound bed was 90% slough and 10% granulation. The skin texture, moisture, and color were normal. No signs or symptoms of infection. There was no change noted in the wound progression. A debridement was performed where muscle and subcutaneous tissue were removed along with slough. The resident reported no pain during the procedure. Post debridement measurements were 4.5 cm x 5 cm x .3 cm. Wound treatment orders remained the same to clean the wound with normal saline, apply Dakin's gauze and cover with an ABD pad twice daily. Healing was expected to be delayed due to inevitable effects of aging. -Review of the resident's December 2021 TAR revealed wound care was not provided on 12/18/21 on the evening shift. -The wound had decreased in size, which showed the wound had the ability to heal. Laboratory testing was ordered and completed on 12/19/21. Results on 12/20/21 revealed a critical lab result of white blood cells 26.4. The physician was notified of the result and would come to facility to assess resident in the facility. Vital signs were at baseline and the resident had no complaints of pain or discomfort. The physician assistant assessed the resident in the facility on 12/20/21 at 10:10 a.m. and ordered a urinalysis and chest x-ray. A physician assistant note dated 12/20/21 read: Today the wound care doctor saw her and her coccyx wound has continued 90% slough. They will continue the Dakin's twice daily. Patient with chronically high WBC (white blood cell) count but now more anemic. History of having IV (intravenous) iron in May 2021 as well as 2 units of packed RBCs (red blood cells). She is not currently on any iron. Patient continues to eat very small amounts of food. She has not been willing to work with speech therapy so that they can clear her for an upgrade in her diet and so mostly she is getting her nutrition through the Glucerna both during the day p.o. and Overnight through G tube. Patient says that she is doing well today. No sign of acute respiratory or abdominal symptoms. A physician assistant note dated 12/22/21 read: 12/20 UA (urinalysis) showed leuk (leukocytes, white blood cells) est, bacteria and wbc (white blood cells) but neg (negative) nitrate. no dysuria (painful urination) or fever or hematuria (blood in the urine). foley (catheter) working well. CXR (chest x-ray) no acute disease. No new orders were written related to the lab results. A nutrition note dated 12/20/21 revealed the RN reported the resident continued to only eat bites of food and had started to decline supplements and tube feedings. The resident was declining feeding assistance. RD spoke to resident and encouraged PO (by mouth) intake and educated the need for increased intakes for wound healing, resident stated she would eat her food later but declined to eat any during visit. Recommended increased PO glucerna supplement and changes to rate and run time of nocturnal tube feedings to encourage PO intake at meal times. Glucerna 1.2 at 76 ml per hour for 8 hours via gtube. Provides 608 ml enteral nutrition per day, 730 kcals, 36.5 g protein and 489.4 ml water. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A new order was written on 12/20/21: Enteral Feed Order every shift Glucerna 1.2 @ 76 mL/hr x 8 hr (on 1900, off 0300) via g-tube. (Provides 608 mL EN/day, ~730 kcal/day). From 12/20/21 to 1/5/22: Glucerna four times a day related to type 2 diabetes mellitus without complications (E11.9) 8 oz Glucerna or equivalent QID (4x/day) for nutrition support. Provide bolus via g-tube for wound healing. Flush with 30 mL water before and after bolus. The resident was seen by the wound care physician during rounds on 12/20/21. The notes revealed the coccyx wound was an unstageable pressure injury obscured full thickness skin and tissue loss. Measurements were 4.5 cm x 5 cm with no measurable depth. Bone was exposed and the resident reported no pain. The wound bed was 90% slough and 10% granulation. The skin texture, moisture, and color were normal. No signs or symptoms of infection. There was no change noted in the wound progression. A debridement was performed where muscle and subcutaneous tissue were removed along with slough. The resident reported no pain during the procedure. Post debridement measurements were 4.5 cm x 5 cm x .3 cm. Wound treatment orders remained the same to clean the wound with normal saline, apply Dakin's gauze and cover with an ABD pad twice daily. Healing was expected to be delayed due to inevitable effects of aging. -Review of the resident's December 2021 TAR revealed wound care was not provided on 12/29/21 on the evening shift. The resident went home with family overnight for 72 hours from 12/25/21 to 12/28/21. All medications, tube feeding supplies, and wound supplies were provided to the family. Resident's daughter is an RN (registered nurse) and was able to complete all ordered care. An order was written on 12/20/21 to confirm the home visit: Pt (patient) may have a 72 hr (hour) pass with family 12/25-12/27/21. MDPOA (medical durable power of attorney) is an RN and willing to do wound care dressing and Gtube feedings. Please send pt with routine meds, dakin's solution and appropriate other wound care dressings, with her Oxycodone and with her nebulizer machine and nebulizer meds and insulin (pt has glucometer at home). Also send with 12 cans of glucerna and a syringe that can be used for g tube bolus feeding since will not use a pump at the home. A nursing note dated 12/27/21 revealed the nurse received a phone call from the resident's daughter to remain with the family until 12/28/21. Daughter reported the resident had been doing well at home, all medications were given and wound care treatments twice a day were done well. On 12/28/21 when the resident returned to the facility wound care was provided and the wound measured 5 cm x 5 cm with no measurable depth. No foul odor and no drainage. -However, this was an increase in the size of the wound from 12/20/21 and was not reported to the physician. In addition, there was no comprehensive assessment by the IDT. On 12/29/21 a nutrition note revealed the resident's PO intakes continued to be low between 0-25%, continue on tube feedings as ordered and recommended to increase liquid protein to three times a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A new order was written on 12/29/21 to 1/5/22: Prostat three times a day 30 mL Active Protein Liquid or equivalent TID for wound healing. Provide via g-tube. Flush with 30 mL water before and after administration. A nursing note dated 12/31/21 revealed an order for an x-ray to rule out osteomyelitis (bone infection). The x-ray technician was in the facility, but could not complete the x-ray as the machine was too small for the resident's weight. The resident would need to go out to the hospital for imaging. The wound nurse and physician assistant were notified. A new order was written to schedule an open sided MRI as soon as possible to rule out osteomyelitis. -The MRI was scheduled for 1/12/22, which was 12 days later which was the earliest the facil[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33298 Based on record review, observations and interviews, the facility failed to ensure catheter orders were followed and catheter care was provided according to physician orders for two (#2 and #8) out of 11 sample residents. Specifically, the facility failed to: -Ensure intermittent catheterization orders were followed for Resident #2; and, -Ensure a resident with a catheter, Resident #8, had an appropriate order to flush the resident's catheter, to include frequency and amount and type of fluid to perform the catheter flush. Findings include: I. Facility policy and procedure The Catheter Care policy, revised September 2014, was provided by the assistant nursing home administrator (ANHA) on 2/1/22 at 4:47 p.m. It read, in pertinent part: The purpose of this procedure is to prevent catheter associated urinary tract infections. Managing obstructions: if the catheter material is contributing to the obstruction, notify the physician and change the catheter if instructed to. Catheter irrigation (flushing) may be ordered to prevent obstruction if the resident is a risk for obstruction. The Guidelines for Charting and Documentation policy, revised April 2021, was provided by the NHA on 2/1/22 at 5:03 p.m. It read in pertinent part: Physician Orders: The following information is provided to assist in recording physicians' orders. -Supervision of a Physician: Each resident must be under the care of a licensed physician authorized to practice medicine in this state and must be seen by the physician at least every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter. Physicians' orders must be signed by the physician and dated when such an order was signed. Current lists of orders must be maintained in the clinical record of each resident. Orders must be written and maintained in chronological order. Physician orders must be reviewed and renewed every 30 days . -Content of orders: Treatment Orders: Specify what is to be done, location and frequency, and duration of the treatment II. Resident #2 A. Resident status (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2, age 53, was admitted on [DATE] and discharged on [DATE]. According to the November 2021 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, gastrostomy infection, type II diabetes mellitus, moderate protein calorie malnutrition, chronic obstructive pulmonary disorder, biliary cirrhosis, cystitis without hematuria, and end stage renal disease. The 11/24/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required extensive assistance of one to two staff members with mobility and activities of daily living (ADLs). B. Record review A urine retention care plan initiated 10/5/21 read: Resident is at risk for urine retention and urinary tract infections due to benign prostatic hypertrophy. Resident receives Flomax. Interventions included: Administer medications as ordered; Encourage good fluid intake; Encourage resident to report any pain, burning or difficulty urinating; Monitor for bladder distention and discomfort; Monitor for side effects of medication; Monitor for changes in color, consistency, amount, frequency. Request a urinalysis with culture and sensitivity to rule out infection with follow up as needed. Review of the resident's CPO revealed an order from a physician assistant on 10/19/21 which read: Straight cath twice daily. Has full bladder sensation. Review of the resident's treatment administration record (TAR) for October and November 2021 revealed the above order was not on the administration record and the treatment was not provided by staff. Review of the resident's CPO revealed an order on 10/23/21 which read: Straight cath resident every three days. If only collecting a scant amount of urine, may contact MD to get a new order to straight cath every four days. Every night shift every three days for urinary retention. -Review of the resident's TAR for October and November 2021 revealed the resident was not straight cathed on 10/23/21, 11/1/21, 11/7/21, 11/13/21, 11/16/21, or 11/22/21. -The facility did not follow the order six out of 12 scheduled times. C. Interviews The director of nursing (DON) was interviewed on 2/1/22 at 4:14 p.m. She stated the nurse who verified the original order for straight catheterization on 10/19/21 did not ensure the order was categorized correctly, so the order did not transfer to the MAR/TAR. She stated the order for catheterization every three days should have been followed and there should not be any holes on the MAR. She stated one instance the resident was at dialysis, though that should be reflected in the documentation and not left blank. She stated not following physician orders for catheterization could lead to infection or other bladder issues. 41032 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #8 A. Resident status Resident #8, age 79, was admitted on [DATE]. According to the January 2022 computerized physician orders (CPO), the diagnoses included kidney failure, retention of urine, benign prostatic hyperplasia and hematuria. The 12/13/21 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required extensive assistance of one to two staff members with mobility and ADLs; and had an indwelling catheter. B. Observation and interview Licensed practical nurse (LPN) #2 was interviewed on 2/1/22 at 10:55 a.m. LPN #2 was asked if she was responsible to perform any type of catheter care with Resident #8. LPN #2 said she was responsible for performing routine catheter care by flushing the resident catheter to prevent clogging of the tube. LPN #2 was observed on 2/1/22 at 10:58 a.m., while flushing Resident #8's catheter. LPN #2 gathered supplies and proceeded to flush Resident #8's catheter with 60 cubic centimeters (cc) of normal saline. Using aseptic technique LPN #2 pushed the saline into the resident catheter using a large syringe through the urine drainage port; after a few seconds the nurse pulled the fluid out of the catheter back into the syringe. The resident urine was clear with a scant amount of sediment. LPN #2 said this task was performed to make sure the resident catheter did not get clogged, ensuring urine flowed freely from the bladder through the catheter inserted into the resident's bladder. The tube had been clogged in the past. C. Record review Review of the resident's CPO revealed the following order related to the resident catheter. -Foley catheter 16 French with 10 cc bulb, Change as needed for obstructive neuropathy, start date 1/27/22. Diagnosis was changed from urethral stricture, start date 9/29/21. -Change Foley catheter once monthly on the 28th, provide peri-care every shift and as needed, start date 3/3/21. -Change drainage bag every two weeks and as needed, every night shift, start date 4/12/21. -Check Foley leg strap for placement and change as needed, every shift, start date 4/12/21. -Foley catheter care every shift for stretching distal to membrane urethra, start date 1/4/21. -There was no order to flush the resident catheter. D. Additional staff interviews (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 2/1/22 at 4:02 p.m. LPN #1 said there should be an order to flush a resident catheter if the doctor deemed necessary. The purpose of flushing the resident catheter would be to clear any blockage in the catheter. If there was no order and the resident catheter needed to be flushed, the nurse should contact the resident physician for orders. If the order were not clear or did not give specific parameters the nurse should contact the doctor for specific parameters for administration of a prescribed amount and type of fluid to flush the catheter. Orders were to include the route of administration, duration and frequency of administration or other patient information. The LPN said it was standard practice to flush a blocked resident catheter with 60 cc of normal saline. If the procedure was necessary, the nurse should notify the physician of the blockage and need to flush the catheter. The assistant director of nursing (ADON) was interviewed on 2/1/22 at 4:20 p.m. The ADON reviewed the resident orders and confirmed there was no order to flush the resident catheter. The ADON said the nurse should always verify there is an order prior to performing any medical treatments. The ADON said he would contact the doctor and discuss the resident catheter care needs and request an order if appropriate. E. Follow-up The ADON reported the residential physician provided an order that read: Foley catheter: flush with 60 cc for blockage or leaking of foley catheter, as needed for foley care, start date 2/1/22.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41032 Based on observations and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of two resident (#6) observed during wound care. Specifically, the facility failed to: -Perform hand hygiene during wound care with Resident #6 when removing used gloves and before putting on clean gloves, after handling dirty or potentially contaminated surfaces and moving to handling clean surfaces, and when opening the universal treatment supply cart and handling the clean wound care supplies (cross-reference F686); -Maintain infection control practices to prevent potential contamination of the treatment supply cart and used wound care supplies when the cart was brought into a resident room and items were handled by staff during a procedure and prior to proper hand hygiene practices; and, -Consistently perform hand hygiene during incontinent care when removing used gloves and before putting on clean gloves, when moving from touching a soiled item, trash or potential contaminate item or body part to touching a clean surface; during care with Resident #6. Findings include: I. Professional standards According to the CDC, Hand Hygiene Guidance, last reviewed 1/30/2020, retrieved 2/3/22 online from https://www.cdc.gov/handhygiene/providers/guideline.html, recommendations for appropriate hand hygiene for infection control included in pertinent part: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient, -Before performing an aseptic task or handling invasive medical devices, -Before moving from work on a soiled body site to a clean body site on the same patient, -After touching a patient or the patient's immediate environment, -After contact with blood, body fluids, or contaminated surfaces, -Immediately after glove removal. Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered, -Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. II. Facility policy The Hand Hygiene policy, revised October 2020, provided by the nursing home administrator (NHA) on 2/1/22 at 4:30 p.m., read in pertinent part: The facility considers hand hygiene the primary means to prevent the spread of infections. - All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. - Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene. -Hand hygiene is the final step after removing and disposing of personal protective equipment. -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine -Hand hygiene is recognized as the best practice for preventing healthcare associated infections. -Applying and Removing Gloves 1. Perform hand hygiene before and after applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. III. Improper wound cleaning A. Observation Incontinent care and wound care for Resident #6 was observed on 1/27/22 from 10:37 a.m. to 12:02 p.m. -Certified nurse aides (CNAs) #1 and #2 entered the room and put on clean gloves without performing hand hygiene. CNA #1 got an adult brief and incontinent pad from the closet and the CNAs informed the resident they were going to get him changed. Resident #6 said it was ok and let the staff remove his brief and roll him on his side. CNA #2 helped the resident stay on his left side as CNA #1 cleaned up the resident and began to remove the soiled lines. CNA #1 put the used wipes in the trash, removed the used gloves and went to the resident's closet to get a clean sheet. The CNA did not perform hand hygiene after cleaning the resident and removing the used gloves. CNA #1 returned to the bedside with clean gloves, placed the clean brief, incontinent pad, clean sheet under the resident, and pushed the soiled linens under the resident. CNA #2 assisted the resident to roll to the right side to remove the soiled brief and linens. CNA #2 removed the soiled items and pulled the clean items through. CNA #2 put the brief in the trash and the soiled linens in a separate bag, changed gloves and returned to the resident bedside without performing hand hygiene. The CNAs rolled the resident back to the left side so the nurse could perform wound care on the resident's left hip. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 entered the room bringing the entire wound care treatment cart into the room to the bedside. The RN washed her hands with soap and water at the sink in the resident room and prepared the wound treatment supplies from the treatment cart and placed the supplies on the top of the cart with no barrier on the top of the cart. The RN removed the old wound dressing from the resident coccyx area. The RN removed the used gloves and put on new gloves without performing hand hygiene. The RN opened gauze pads and cleansed the resident wound with a wound cleaner. The RN removed her gloves, used hand sanitizer on the palms only and put on clean gloves from the box on the wall where the CNAs got their gloves from when they did not perform hand hygiene. RN #1 applied zinc oxide with a gloved hand to the resident entire coccyx wound, change gloves without performing hand hygiene and applied a new dressing on the resident coccyx area and waited while the CNAs changed the resident a second time due to urinating a little on the brief. CNA #2 had to go into the resident closet for a clean brief and incontinent pad. CNA #2 did not perform hand hygiene after handling the soiled items and going to the resident's closet. The CNA handled several items in the closet and went back to the bedside with a clean brief and incontinent pad. After changing the resident, positioning the sheets and rolling the resident to the right side of the bed, the CNAs placed the soiled brief and linens in a bag and changed gloves. CNA #2 did not perform hand hygiene. RN #1 prepared to change the wound dressing on the resident's left hip. The nurse removed the old wound dressing and changed her used gloves but did not perform hand hygiene. The RN cleansed the wound and started to apply a new bandage realizing she did not have the correct supplies; the RN removed her gloves and opened the treatment cart without performing hand hygiene. RN #1 touched several unused wound care items within the wound care supply cart in order to find the items needed to complete the resident wound care and redressing of the wound. Once the items were found RN #1 finished dressing the resident's wound. The RN removed the wrappers from the bedside and removed her gloves. The RN used hand sanitizer and waited for the CNAs to finish changing the resident. The RN then prepared to treat the wound on his left heel. The RN applied glean cloves she again retrieved from the same box where the CNAs got their gloves from. The RN removed the old wound dressing and changed gloves. She did not perform hand hygiene before putting on new gloves to clean the resident heel wound. The RN removed the used gloves and without performing hand hygiene, RN #1 then went into the treatment cart for additional supplies. RN #1 touched several unused items in the treatment cart as she retrieved the needed wound care supplies from the cart. The RN finished the resident's wound care. The RN removed the treatment cart from the resident bedside and placed it in the hall without cleaning the top of the cart. B. Interviews RN #2 was interviewed on 1/17/22 at 12:04 p.m. RN #1 said hand hygiene was important to not spread germs. It was important for staff to change gloves when moving from one task to the next and that staff should perform hand hygiene after touching a dirty or solid surface and before touching another surface. CNA #1 was interviewed on 1/27/22 at 2:15 p.m. CNA #1 said staff were expected to perform hand hygiene before providing care to any resident, after each glove change, and after touching a soiled item. Hand hygiene was important for infection control. (continued on next page)

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	065146	A. Building B. Wing	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampden Hills Post Acute	14699 E Hampden Ave Aurora, CO 80014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nurses (DON) was interviewed on 1/28/22 at 12:35 p.m. The DON said staff needed to perform hand hygiene with every glove change. Antibacterial hand sanitizer was an acceptable form of hand hygiene. It was particularly important for staff to perform hand hygiene after completing incontinent care, handling trash, and in-between tasks of wound care especially after a glove change. The DON said the nurse was never to take the entire treatment cart into a resident room. The nurse should have gathered needed supplies to bring into a resident room. The supplies should have been set up onto a clean field. If the nurse needed an additional item from the wound treatment supply cart the nurse should have washed her hands thoroughly before touching items in the supply cart that would potentially be used for other resident wound care treatments. The DON said she would be providing all staff an in-services on hand hygiene and educating RN #1 on proper techniques of infection prevention during wound care.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 33298 Based on record review, observations and interviews, the facility failed to maintain an effective pest control program so the facility was free from pests and rodents. Specifically, the facility failed to ensure the facility was kept free from cockroaches. Findings include: I. Facility policy and procedure The Pest Control policy was provided by the assistant nursing home administrator (ANHA) on 2/1/22 at 4:47 p.m. It read, in pertinent part: This facility maintains an on-going pest control program to ensure that the building is kept free from insects and rodents. Pest control services are provided by (contracted pest control company) Windows are screened at all times. Only approved FDA and EPA insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. Garbage and trash are not permitted to accumulate and are removed from the facility daily. Maintenance services assist, when appropriate and necessary, in providing pest control services. II. Record review A. Grievances Grievances for the past three months were reviewed and revealed: -On 12/27/21 a resident reported seeing several roaches on her floor next to her bed. She crushed one in her doorway and another roach went under her recliner. The maintenance director sprayed the room and saw no roaches. The exterminators were called and would visit the facility the next day. -On 12/30/21 a resident reported seeing roaches in his bathroom and on the floor in his room. The maintenance director sprayed the room and saw no roaches on the floor. -On 1/18/22 a resident reported seeing roaches in her room. The exterminators visited the facility and sprayed her room on 1/20/22. B. Pest control records (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility pest control records for the past six months were reviewed and revealed the facility received pest control services monthly. The facility was on the roach, fly and mouse programs. -On 11/9/21 a cockroach was found in a resident room. -On 12/17/21 three resident rooms were treated for cockroaches. III. Observations and resident interviews On 2/1/22 at 10:12 a.m. Resident #9's room was observed. The room was very cluttered with clothing, boxes, stuffed animals, tchotchkes, papers and magazines, and food products. She stated she knew she needed to get the room cleaned up and get rid of multiple items. She stated the pest control company did come in to spray, though she was still seeing roaches in her room frequently. She stated the whole facility needed to be treated rather than just individual rooms. On 2/1/22 at 10:35 a.m. Resident #10 was interviewed and her room was observed. The room was large and not very cluttered, though there was noticeable food on the floor. Resident #10 stated she frequently saw roaches in her room and had told the staff about them but nothing had been done to try to treat them as far as she knew. She stated the roaches came out at night more frequently than during the day. On 2/1/22 at 12:17 p.m. Resident #11's room was observed. The room was clean and there was not much clutter. A small cockroach was observed crawling on the baseboard under the sink. The roach crawled along the wall and crawled behind the baseboard in the corner where there was a small area the baseboard had peeled away from the wall. Resident #11 stated he frequently saw cockroaches in his room. He stated they were more active at night. He stated the facility staff had sprayed his room a few months ago, but it had no effect to control the roaches in his room. He stated he placed a couple over-the-counter roach killing products to try to treat them himself. IV. Staff interviews Housekeeper (HK) #1 was interviewed on 2/1/22 at 12:12 p.m. He stated he had worked in the facility for a few weeks and he had seen cockroaches in the facility. He stated he killed them with his broom and reported the pest activity to his supervisor and to maintenance. Maintenance assistant (MA) #1 was interviewed on 2/1/22 at 3:30 p.m. He stated when they received a report about pests in the facility, the pest control company was called and they came out to spray the room. He stated the licensed exterminators had to perform the treatments. He stated the most common pest complaints they received were spiders and cockroaches. He stated there was an active cockroach problem in the facility and they had just made a plan with the pest control company to treat the whole facility. The maintenance director (MD) was interviewed on 2/1/22 at 4:00 p.m. He stated the pest control company came to the facility at least once a month. He stated the facility was treated monthly and as needed if they received a report from residents. He stated they had been receiving reports of cockroaches for the past few months and the specific rooms had been treated. He stated the facility and pest control company made a plan to treat the whole facility where they would come in weekly and treat each hallway and each room individually. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The nursing home administrator was interviewed on 2/1/22 at 5:00 p.m. She stated the facility did have an active cockroach problem and the whole facility needed to be treated.