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	04/22/2021

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on record review and interviews, the facility failed to ensure residents receive showers based on their schedules, consistent with their interests, assessments, and care plans for three (#2, #127 and #8) of four residents reviewed for shower preferences of 68 sample residents. Specifically, the facility failed to provide Resident #2, Resident #127 and Resident #8 showers/bathing according to their schedule/preferences. Cross-reference F725 for sufficient staffing. Findings include: I. Facility policy and procedure Review of the Activities of Daily Living (ADLs) policy, revised March 2018, provided by the assistant nursing home administrator (ANHA) on 4/20/21 at 4:53 p.m. revealed in part Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing) . II. Resident #2 Resident #2, age 62, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included epilepsy, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or inability to move one side of the body), cerebral infarction (stroke) and history of falling. The 3/30/21 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The functional status for bathing was documented as activity itself did not occur. The resident did not have any behaviors documented, including no rejection of care. Resident #2 was interviewed on 4/12/21 at 3:08 p.m. He said he had not received any showers. He said the staff marked off that he refused, but he did not. He said they provided bed baths, but that was not a shower. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was interviewed again on 4/21/21 at 10:21 a.m. He said he got a shower the night before, for the first time this calendar year. He said they changed the shower schedule at times. He said his shower days used to be on Monday and Thursday. He said, lately the days have been different. He said he would like showers at least twice a week. Review of the care conference meeting notes, dated 8/19/2020, revealed in part Summary of care plan conference discussion: consistency in care, only three showers in one year . The care plan, initiated 10/21/19, revealed in part (Resident) has made statements regarding not having all of his needs met. Interventions included: Learn (resident) routine .Staff to meet (resident) needs and requests in a timely manner .Take all accusations that (resident) makes seriously and investigate following facility protocol. The care plan, revised 3/16/2020, revealed in part The resident has limited physical mobility related to contractures, weakness, hemiplegia. Interventions included: Two person care at all times, two person max assist with (mechanical) lift: due to safety changes .Resident requires mod to max assist in completing ADLs. Review of the February 2021 documentation survey report for showers and handwritten bathing documentation for showers revealed the schedule for Tuesday and Friday evenings. The handwritten documentation revealed the resident refused a shower on 2/1/21 and six additional forms, undated. The undated forms revealed the resident had a bed bath for one day and three refused shower days. According to the residents schedule, the resident had one shower in February 2021. The rest of the documentation was blank or marked as not applicable. Review of the March 2021 documentation survey report for showers revealed the schedule for Tuesday and Friday evenings. The resident had two bed baths for the month of March 2021. The rest of the documentation was blank or marked as not applicable. Review of the April 2021 documentation survey report for showers revealed the schedule for Tuesday and Friday evenings. The resident did not receive any showers or bed baths for the month of April 2021. The rest of the documentation was blank or marked as not applicable. III. Resident #127 Resident #127, age 40, was admitted on [DATE]. According to the April 2021 CPO, diagnoses included anxiety, protein-calorie malnutrition, major depression disorder, type 2 diabetes mellitus, cerebral infarction, unspecified injury at C4 level of cervical spinal cord, type 1 diabetes mellitus and muscle wasting. The 3/8/21 MDS assessment revealed the resident had intact cognition with a BIMS score of 15 out of 15. Active diagnosis included: wound infection, cerebrovascular accident, quadriplegia and malnutrition. The functional status for bathing was documented as activity itself did not occur. The resident exhibited verbal behavior symptoms that occurred one to three days. Rejection of care was documented as occurring four to six days. Review of the care conference meeting notes, dated 2/16/2021, revealed in part Special requests/choices/conditions: Shower three times a week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bathing preference sheet, dated 2/3/21, revealed in part Current bathing days are on Wednesday and Saturday evening (pm). Do those days work for you? Yes. Review of the care plan, revised 4/15/21, revealed in part The resident has ADL self-care performance deficits related to quad status, muscle wasting, lack of coordination and multiple wounds. Interventions included: (Mechanical) lift with two staff members for all transfers .Bathing/showers: provide sponge bath when a full bath or shower cannot be tolerated. The resident was interviewed on 4/12/21 at 2:20 p.m. He said he did get bed baths, but he got them when he got them. Review of the February 2021 documentation survey report for showers and handwritten shower/bathing documentation revealed the schedule was Tuesday and Friday day shift. There were two undated handwritten forms which indicated a bath/shower was provided. According to the residents schedule, the resident had three showers and one bed bath in February 2021. The rest of the documentation was blank or marked as not applicable. Review of the March 2021 documentation survey report for showers revealed the schedule was Tuesday and Friday day shift. The resident had one shower and one bed bath for the month of March 2021. The rest of the documentation was blank or marked as not applicable. Review of the April 2021 handwritten shower/bathing documentation revealed the resident had four completed showers/bed baths in April 2021. The forms were not documented as to whether the resident received a shower or a bed bath. There was no computerized documentation for any showers/baths provided for April 2021. IV. Resident #8 A. Resident status Resident #8, age less than 60, was admitted on [DATE]. According to April 2021 CPO, diagnoses included polyneuropathy, asthma, diabetes mellitus, difficulty walking, muscle weakness, depressive episodes, acute embolism and thrombosis. The 1/4/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required limited one-person assistance with most activities of daily living (ADLs) and one-person physical help in part of bathing activity. B. Resident interview Resident #8 was interviewed on 4/12/21 at 2:54 p.m. He said he was not receiving his showers routinely. C. Record review The care plan, initiated on 1/15/21 revealed Resident #8 required limited one-person assistance with showering. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's electronic record report for showers and handwritten bathing documentation for showers revealed the schedule for Tuesday and Friday evenings. Review of handwritten documentation for February 2021 revealed the resident had a shower on 2/9/21 and 2/12/21, he was in the hospital on 2/19/21 and refused a shower on 2/26/21. According to Resident #8's schedule and the electronic record, the resident had three showers in February 2021 and was otherwise blank in the record. Review of handwritten documentation for March 2021 revealed Resident #8 had no documentation of a shower being given for the month of March 2021. According to Resident #8's schedule and the electronic record, the resident had four showers in March 2021 and otherwise was blank in the record. Review of handwritten documentation for April 2021 revealed Resident #8 received a shower on 4/2/21 and 4/6/21. According to Resident #8's schedule and the electronic record from 4/1/21 to 4/20/21 the resident only received two showers in three weeks. V. Staff interviews CNA #12 was interviewed on 4/12/21 at 6:17 p.m. She said when they worked short staffed she could not complete all assigned showers. CNA #13 was interviewed on 4/13/21 at 4:53 p.m. She said when they worked short staffed she could not complete all assigned showers residents who were less vocal were the residents who most likely would not receive their shower. The assistant director of nursing (ADON) was interviewed on 4/21/21 at 5:35 p.m. He said he was aware of staffing concerns and staff were not able to complete shower assignments, but the facility was doing their best ensure residents received their showers. Certified nurse aide (CNA) #6 was interviewed on 4/15/21 at 2:01 p.m. She said she made sure she got the showers done when she was working. She said she tried to do as much as she could or pass to the next shift. She said the shower aide left (not working at the facility any longer). Unit manager (UM) #1 was interviewed on 4/15/21 at 2:02 p.m. He said they did not have a shower aide right now. He said she quit about one to two months ago. He said the CNAs on the floor were providing the showers. Licensed practical nurse (LPN) #2 was interviewed on 4/20/21 at 12:47 p.m. She said they had a shower schedule. She said if the resident refused, the nurses would document this in the progress notes or bath sheets. She said they used to have a shower aide. CNA #5 was interviewed on 4/20/21 at 1:11 p.m. She said the facility used to have a shower aide. She said if the resident refused the shower, then they would put refused in the documentation. She said they would mark did not occur or not applicable if it was a different date or time than the planned schedule. She said they had many showers at a time, scheduled. She said they could have four showers for Monday and five showers for Thursday. She said one shower might get missed per week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #20 was interviewed on 4/20/21 at 2:07 p.m. She said that showers got missed sometimes. She said they had three to four showers scheduled in a day, so it was difficult getting them done. She said some CNAs were completing showers after their shift was over. The director of nurses (DON) was interviewed on 4/20/21 at 2:29 p.m. She said the shower documentation would be in the task section in the electronic records and bath sheets. She said bathing got better and then, working on the shower situation. She said the staff may not be documenting all of the showers provided, or it was documented in different areas. She said some residents would say they wanted a shower and then refused. She said she was working on the documentation. She said the facility had a shower aide, but the residents were refusing to shower. She said the facility may need to add a new shower aide for the residents. 38503

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on record review and interviews, the facility failed to notify the resident representative for one (#88) of three reviewed out of 68 sample residents. Specifically, the facility failed to ensure Resident #88's power of attorney (POA) was notified of a change in condition. I. Facility policy The Physician/Family Notification policy, undated, was provided by the director of nursing (DON) on 4/20/21 at 10:49 a.m. It documented in pertinent part, Purpose to ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories: -An accident resulting in injury and that has the potential for needed physician intervention. -A significant change in the resident's physical, mental or psychosocial status. -A need to significantly alter treatment. -Transfer of the resident from the facility. II. Resident status Resident #88, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included chronic osteomyelitis (bone infection), presence of prosthetic heart valve, thrombosis (formation of blood clot) due to cardiac prosthetic devices, absence of left leg (below the knee), morbid obesity and diabetes mellitus. The 2/11/21minimum data set (MDS) assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive two-person assistance with all activities of daily living (ADLs) and was totally dependent for bathing. III. POA interview Resident #88's POA was interviewed on 12/31/2020 at 10:00 a.m. (prior to survey). She said she was not notified of resident changes (such as changes in care conference schedules) when required. -She could not be reached during the survey for further comment. IV. Record review Review of Resident #88's profile revealed she was her own responsible party; however, documentation revealed Resident #88 had a power of attorney (see below). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medical Durable Power of Attorney for Healthcare Decisions, dated 4/7/17, for Resident #88 was in effect and signed by the resident. Review of Resident #88's progress notes from February through April 2021 revealed her POA was not notified of Resident #88's start of antibiotic therapy for urinary tract infections (UTIs) on 2/21/21 and 3/24/21 (see below). The nurses note dated 2/21/21 at 9:00 p.m., revealed Resident #88 had abnormal lab values which were called to the physician. There were new orders to start the resident on antibiotics, the resident was notified of the new orders. -However, there was no documentation of Resident #88's POA being notified. The nurses note dated 3/24/21 at 10:20 a.m., revealed Resident #88 complained of pain with urination, back pain, urgency and frequent urination. The physician was notified of the urinalysis report and Resident #88 was started on antibiotic therapy. -There was no documentation of Resident #88's POA being notified. V. Staff interview The nursing home administrator (NHA) and DON were interviewed on 4/22/21 at 8:14 a.m. The DON said the floor nurses were responsible for ensuring the resident's responsible party or POA were notified that a resident was started on antibiotics for UTI and for any change in condition. VI. Follow-up On 4/22/21 at 9:10 a.m. provided a of copy education that was started with licensed nurses (nine nurses) and updated copy of Resident #88's profile sheet to include the name and phone number of POA.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on record review and interviews, the facility failed to ensure residents will have a person-centered comprehensive care plan developed and implemented to meet other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for four (#127, #166, #146 and #161) of 68 sample residents. Specifically, the facility failed to: -Provide a comprehensive care plan including skin integrity/wound care/pressure injury development for Resident #127; -Ensure anticoagulant usage monitoring was included on the care plan for Resident #166 and Resident #146; and, -Ensure Resident #161's had a care plan for falls and pain management after returning from the hospital. Findings include: I. Facility policy and procedure Review of the Care Plans, Comprehensive Person-Centered policy, revised December 2016, provided by the nursing home administrator (NHA) on 4/21/21 at 2:51 p.m. revealed in part The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive , person-centered care plan will .Include measurable objectives and timeframes; Describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being; Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment .Include the resident's stated goals upon admission and desired outcomes .Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Build on the resident's strengths; Reflect the resident's expressed wishes regarding care and treatment goals; Reflect treatment goals, timetables and objectives in measurable outcomes; Identify the professional services that are responsible for each element of care; Aid in preventing or reducing decline in the residents functional status and/or functional levels; Enhance the optimal functioning of the resident by focusing on a rehabilitation program; and Reflect currently recognized standards of practice for problem areas and conditions. II. Resident #127 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #127, age 40, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included anxiety, protein-calorie malnutrition, major depression disorder, type 2 diabetes mellitus, cerebral infarction, unspecified injury at C4 level of cervical spinal cord, type 1 diabetes mellitus and muscle wasting. The 3/8/21 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The resident exhibited verbal behavior symptoms that occurred one to three days. Rejection of care was documented as occurring four to six days. Active diagnosis included: wound infection, cerebrovascular accident, quadriplegia and malnutrition. The resident was at high risk of developing pressure ulcers/injuries. The resident had one unstageable-slough and/or eschar and two unstageable- deep tissue injuries. There were no venous or arterial ulcers presented. The baseline care plan, signed 2/10/21, revealed skin risk was not marked for current skin integrity issues or history of skin integrity issues. There were no care plans in place for skin integrity/ pressure areas from resident admission 2/3/21 to 4/12/21 (during survey). A. Care plans implemented during survey (cross-reference F686 for pressure ulcers) The care plan, initiated 4/12/21, revealed in part The resident has a stage 4 pressure ulcer sacral/coccyx extending into buttock power of attorney (POA) 2/3/21 related to disease process spinal cord injury, immobility, smoking. Measurements: 10.1 centimeters (cm) x 5.5 cm x 5.0 cm. Interventions included: The resident encouraged to have bed as flat as possible to reduce shear .Administer medications as ordered . Administer treatment as ordered and monitor for effectiveness .Air mattress .Assess/record/monitor wound healing weekly .Educate the resident/family caregivers as to causes of skin breakdown .Encourage and support smoking cessation .Inform the resident/ family/ caregivers of any new area of skin breakdown . Monitor nutritional status .Obtain and monitor lab/ diagnostic work as ordered .Sacral coccyx wound .Teach resident/ family the importance of changing positions for prevention of pressure ulcers .The resident needs assistance to turn/reposition .The resident prefers to be positioned on back with pillows under both shoulders and height of bed (HOB) above 45 degrees .The resident requires pressure relieving/reducing device .The resident requires dietitian referral .Treat pain as per orders . The care plan, initiated 4/13/21, revealed in part The resident has unstageable pressure injury to right buttock development related to disease process .and immobility. Measurements 3.5 cm x 3.5 cm x undetermined (UTD). Interventions included: Administer medications as ordered .Administer treatments as ordered and monitor effectiveness .Air mattress .Educate the resident/ family/ caregivers as to what causes breakdown .Follow facility policies/ protocols for the prevention/ treatment of skin breakdown .If the resident refuses treatment, confer with the resident, IDT and family .Inform the resident/family/ caregivers of any new area of skin breakdown .Monitor/ document/ report as needed (PRN) any changes in skin status .Obtain and monitor labs/ diagnostic work as ordered .Right buttock .Teach resident/ family the importance of changing positions .Treat pain as per orders .Weekly treatment documentation to include measurement of each area of skin breakdowns . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated 4/13/21, revealed in part The resident has an unstageable ulcer to right heel. Measurements: 1.2 cm x 1.2 cm x 0 cm. Interventions included: Administer medications as ordered . Administer treatments as ordered .Air mattress .Educate the resident/ family/ caregivers as to causes of skin breakdown .Follow facility policies, protocols for the prevention/ treatment of skin breakdown .If the resident refuses treatment, confer with the resident, IDT and family .Inform the resident/ family/ caregivers of any new skin breakdown .Monitor nutritional status .Monitor/ document/ report PRN any changes .Obtain and monitor any lab/diagnostic work as ordered .Right heel .Teach resident/ family the importance of changing positions . Treat pain as per orders prior to treatment/ turning, etc .Weekly treatment documentation to include measurement of each area of skin breakdown . The care plan, initiated 4/13/21, revealed in part The resident has an unstageable pressure injury to the left lateral foot. Measurements: 0.5 cm x 0.5 cm x 0 cm. Interventions included: Administer medications as ordered .Administer treatments as ordered .Air mattress .Educate the resident/ family/ caregivers as to causes of skin breakdown .Follow facility policies, protocols for the prevention/ treatment of skin breakdown . If the resident refuses treatment, confer with the resident, IDT and family .Inform the resident/ family/ caregivers of any new skin breakdown .Left lateral foot .Monitor nutritional status Monitor/ document/ report PRN any changes .Teach resident/ family the importance of changing positions .Treat pain as per orders prior to treatment/ turning, etc .Weekly treatment documentation to include measurement of each area of skin breakdown . The care plan, initiated 4/13/21, revealed in part The resident has a blister to left heel. Measurements: 4.5 cm x 4.5 cm x 0 cm. Interventions included: Administer medications as ordered .Administer treatments as ordered .Air mattress .Educate the resident/ family/ caregivers as to causes of skin breakdown If the resident refuses treatment, confer with the resident, IDT and family .Inform the resident/ family/ caregivers of any new skin breakdown .Left heel blister .Monitor nutritional status Monitor/ document/ report PRN any changes . Teach resident/ family the importance of changing positions .Treat pain as per orders prior to treatment/ turning, etc .Weekly treatment documentation to include measurement of each area of skin breakdown . The care plan, initiated 4/15/21, revealed in part The resident has actual impairment to skin integrity (see multiple wound care plans). He has the potential for further skin injury. Interventions included: (Resident) was evaluated to be an unsafe smoker and needs an adaptive ashtray when smoking .Avoid scratching .Educate resident/ family/ caregivers of causative factors .Encourage good nutrition and hydration .Follow facility protocols .Identify/ document potential causative factors .Keep skin clean and dry .Monitor/ document location, size and treatment of skin injury .The resident has an air mattress .The resident needs pressure relieving/ reducing cushion .The resident needs total assistance of one or two to offload heels and buttocks with position changes and pillows. Use a draw sheet or lifting device .Use caution during transfers and bed mobility .Weekly treatment documentation . The care plan, initiated 4/18/21, revealed in part The resident is non compliant with offloading and proper positioning to reduce pressure. Interventions included Encourage by staff to place pillows under one side of body upper back, above buttocks; resident will agree to put pillows/offloader cushion under legs offloading heels; resident will allow staff to raise the HOB (head of bed) to the lowest possible position . B. Staff interviews (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #1 was interviewed on 4/19/21 at 1:13 p.m. She said the facility had an MDS coordinator completing the MDS assessments remotely. She said she was gone for a while and when she came back, she was told to help complete the resident care plans that were approximately 70 care plans behind. She said they were working at getting the care plans caught up. She said the facility was trying to hire another MDS coordinator. She said the wound nurse was the person responsible for completing the care plans related to wounds. She said they had been behind since about August-September 2020. She confirmed there were no skin care plans for this resident in his chart prior to the survey. The MDS coordinator was interviewed on 4/19/21 at 2:00 p.m. She said she has completed MDSs in this building since December 2020. She said she completed the MDSs virtually. She said she looked at all of this resident's information on admission and she did not see anything related to wounds in the resident's chart. The wound registered nurse (WRN) was interviewed on 4/20/21 at 9:12 a.m. She said she was the staff member who completed the skin care plans. She acknowledged it was not done and it was overlooked. 43134 III. Resident #166 (cross-reference F684 quality of care) A. Resident status Resident #166, age 64, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included amputations of two left toes, peripheral vascular disease, osteomyelitis (bone infection) of right ankle and foot, diabetes, gastrointestinal hemorrhage, melena, atrial fibrillation. The 4/15/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. He required supervision with setup for transfers, walking, eating and personal hygiene and one person assistance with bed mobility, dressing and toilet use. The MDS further documented a health condition for internal bleeding, he received anticoagulant medications. B. Record review The April 2021 care plan for Resident #166 revealed he did not have a focus area or interventions to monitor the resident while he was on blood thinning medications Plavix, aspirin and Lovenox injections, which were necessary due to his recent history of cardiovascular disease and surgical interventions. The April 2021 CPO orders for Resident #166 revealed that the resident had three medications for anticoagulation and antiplatelet, Plavix, aspirin and Lovenox injection. The electronic medical record (EMR) did not include monitoring the resident for abnormal bleeding, examples, melena. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The hospital records for his stay from 4/4/21 until 4/9/21 were retrieved from the resident's electronic chart on 4/14/21. It read that the resident had reported in his initial exam with the doctor he had melena, black tarry stools, for three days. As well as, he has other symptoms of abdominal pain, nausea and diarrhea. He was admitted to monitor for continued bleeding and general health status due to his high risk medications and medical history. C. Interviews The director of nursing (DON) was interviewed on 4/22/21 at 8:30 a.m. She stated she reviewed Resident #166's medications and orders for anticoagulation and antiplatelet, Plavix, aspirin and Lovenox injections (see above) and the medications increased the risk for abnormal bleeding. The provider had responded to the medications where necessary because the resident's history included cardiovascular surgery and circulation obstacles. The resident needed to be closely monitored and include interventions in his care plan and his orders needed to reflect that plan care. -However, neither his care plan or orders revealed that requirement. IV. Resident #146 A. Resident status Resident #146, aged under the age of 60, was admitted on [DATE]. According to the April 2021 CPO, the diagnoses included, respiratory failure with a tracheostomy, congestive heart failure, morbid obesity, deep vein thrombosis right arm, pressure ulcer on heel, muscle weakness, hypertension and hemoptysis (coughing up blood from lungs). The 3/23/21 MDS assessment revealed the resident was cognitively intact with a brief interview for a mental status score of 15 out of 15. He required extensive assistance with one person for bed mobility, dressing, and toilet use. He required supervision with one person to assist in transfer and personal hygiene. He needed supervision while eating and walking in his room, on the unit and locomotion off the unit. He required oxygen therapy, tracheostomy suctioning and care and used physical and occupational therapy. B. Record review The April 2021 orders for Resident #146 revealed an order was initiated on 3/16/21 for Xarelto by mouth, once a day as blood thinning medication for history and treatment of a deep vein thrombosis (blood clot). Review of Resident #146's care plan revealed no monitor for bleeding even though the resident was on anticoagulant therapy. Review of the April 2021 CPO and medication administration record (MAR) revealed there were no orders to monitor for abnormal bleeding while the resident was receiving anticoagulant therapy. C Interviews (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #11 was interviewed on 4/20/21 at 3:30 p.m. He said when residents were ordered blood thinning medications, their risk of abnormal bleeding was added to the care plan and to their orders. The monitoring interventions began when the residents were admitted to the facility or when they began blood thinning medications. Interventions to implement were listed on the care plan to follow what to monitor and the plan for that resident. Licensed practical nurse (LPN) #12 was interviewed on 4/20/21 at 3:40 p.m. She said she used the care plan to know how to care for the residents, what to monitor for and what specific signs or symptoms to monitor. The DON was interviewed on 4/22/21 at 8:45 a.m. She said residents admitted to the facility on a medication that is a blood thinner, their care plans and orders are updated to monitor resident's for abnormal bleeding. The order then reflected on the (medication administration record) MAR. The management team had identified the resident's on blood thinning medications did not have a consistent care plan and orders for all residents to monitor for abnormal bleeding while a resident is receiving anticoagulation medications. 40221 V. Resident #161 (cross-reference F689 falls, F697 pain) A. Resident status Resident #161, age 79, was admitted [DATE] and readmitted [DATE]. According to the November 2020 computerized physician orders (CPO) diagnoses included closed fracture with routine healing, pain in left hip, acute pain due to trauma, aftercare following explantation (removal of tissue) of hip joint prosthesis, unspecified fracture of lumbar vertebrae, Alzheimer's disease. The 11/27/2020 minimum data set (MDS) assessment indicated Resident #161 was rarely/never understood with a brief interview for mental status (BIMS) score of zero out of 15. He was negative for mood and behavior symptoms. He required extensive assistance of two staff members for bed mobility, transfers, and was dependent on one staff member for toilet use and personal hygiene. He had impairment of one side of the lower extremity and used a wheelchair for mobility. He was positive for hip replacement for hip fracture and other fractures. He received scheduled and as needed (PRN) pain medications for facial expressions of pain three to four days of the last five days. He had a surgical incision to his left hip. He received four out of seven days of anticoagulant injections and two out of seven days of opioid pain medication. B. Record review The 9/9/2020 baseline admission care plan indicated he did not require assistance from staff with transfers or walking and he did not use any mobility devices. The 9/9/2020 fall scale evaluation indicated the resident was a low risk for falls as he did not require ambulatory aids and his gait was steady. The 9/9/2020 pain evaluation indicated he had no verbal or non-verbal indicators of pain and the pain evaluation completed on 11/14/2020, after two falls, indicated he was having pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated 9/10/2020 revealed Resident #161 had impaired cognitive function and or thought processes related to Alzheimer's disease. Interventions included to cue, reorient, and supervise as needed. Anticipate and meet needs. -There was no care plan after his return from the hospital on 11/23/2020 for falls or pain management. The 11/23/2020 nursing readmission screening indicated he returned to the facility after a hospital stay for a closed displaced fracture of the left femoral neck and closed fractures of lumbar vertebral bodies. He was dependent on staff for ADLs. The 11/30/2020 physician progress note, following readmission from the hospital for left hip hemiarthroplasty, indicated the resident grimaced with movement and required narcotic pain medication for uncontrolled pain. C. Interviews The MDS coordinator was interviewed on 4/19/21 at 2:16 p.m. She said she would have entered a fall care plan if she happened to catch one that was missing. She said there was a team of staff that were responsible for putting in fall care plans and it was not normally her job. The director of nursing (DON) was interviewed on 4/21/21 at 10:30 a.m. She said when a resident returns to the facility after a hospital stay it was expected for the care plan to be updated with what issues required the hospitalization . She said Resident #161's care plan should have been updated to include falls and pain management after he returned. She said the facility needed to make access for care plan revisions available to all the nurses.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on observation, record review, and interviews, the facility failed to review and revise comprehensive care plans for one (#43) of four residents that included the instructions needed to provide effective and person-centered care out of 68 sample residents reviewed. Specifically, the facility failed to ensure Resident #43's power of attorney (POA) was invited to participate routinely in the care planning revision and/or updated plan of care. Findings include: I. Facility policy The Care plan policy, revised December 2016, was provided by the nursing home administrator on 4/19/21 at 11:30 a.m. It documented in pertinent part, Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: -Participate in the planning process; -Identify individuals or roles to be included; -Request meetings; -Request revisions to the plan of care; -Participate in establishing the expected goals and outcomes of care; -Participate in determining the type, amount, frequency and duration of care; -Receive the services and/or items included in the plan of care; and -See the care plan and sign it after significant changes are made. Assessments of residents are ongoing and care plans are revised as information about the residents and resident's conditions change. II. Resident #43 A. Resident status Resident #43, age less than 60, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included Amyotrophic lateral sclerosis (ALS), Rheumatoid arthritis, schizophrenia anxiety and chronic obstructive pulmonary disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/18/21 minimum data set (MDS) assessment revealed Resident #43 was cognitively impaired with brief interview for mental status (BIMS) score of 11 out 15. She was dependent upon staff for all activities of daily living (ADLs). B. Family interview Resident #43's POA was interviewed on 4/13/21 at 3:23 p.m. She said she routinely was not updated by the facility regarding the resident's care. She said she could recall one time a nurse calling from the facility about the resident having increased secretions. She said she was notified by hospice mainly about comfort care. She said Resident #43's ALS has progressed and she was not able to speak. C. Record review Review of Resident #43's profile revealed her sister was listed on her face sheet as POA. Review of the care conference summaries dated August 2020 and January 2021 were provided by the social services director (SSD) and social services assistant (SSA) #1 on 4/20/21 at 12:18 p.m. The summary documented that SSA #1 contacted the family to make them aware of the care conference the family did not respond. -However it did not document if the POA was contacted at the time of the care conference since she was from out of town and had not received a phone call for care conferences, see POA interview above. Additionally, there was no documentation of a care conference held for quarterly review in November of 2020. D. Staff interview SSD and SSA #1 were interviewed on 4/20/21 at 1:07 p.m. SSA #1 said she typically contacted the families for care conferences and would indicate on the care conference summary form if they participated or if they declined to attend the care conference. The SSD acknowledged there was no care conference review for November 2020 and no further documentation in Resident #43's record that her plan of care had been reviewed with the POA. The MDS coordinator was interviewed on 4/19/21 at 2:11 p.m. She said all staff were responsible for updating the care plans, she did not participate in interdisciplinary review and typically she would receive an email from multiple disciplines for any change in condition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on observations, record review and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) receives the necessary services to maintain good nutrition, grooming, and personal hygiene for four (#111, #127, #95 and #15) of five residents reviewed for ADL care of 68 sample residents. Specifically, the facility failed to ensure: -Residents #111, #127 and #95 received timely meal assistance; and, -Resident #15 received personal hygiene assistance. Findings include: I. Facility policy and procedure Review of the Assistance with Meals policy, revised July 2017, provided by the nursing home administrator (NHA) on 4/20/21 at 5:03 pm. revealed in part Residents shall receive assistance with meals in a manner that meets the individual needs of the resident .Hot foods shall be held at a temperature of 136 degrees or above until served. Cold foods shall be held at 40 degrees or below until service. Nursing and dietary services will establish procedures such that delivery of food to serving areas accommodates this requirement. Review of the Activities of Daily Living policy, revised March 2018, provided by the NHA on 4/20/21 at 5:03 p. m. revealed in part Residents who are unable to carry activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Review of the Food and Nutrition Services policy, revised October 2017, provided by the assistant nursing home administrator (ANHA) on 4/20/21 at 4:53 p.m. revealed in part The food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. II. Meal assistance A. Resident #111 Resident #111, age 58, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included protein-calorie malnutrition, quadriplegia, narcissistic personality disorder, colostomy, muscle weakness, injury at C3 level of cervical spinal cord and weakness. The 2/25/21 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The resident exhibited other behavioral symptoms not directed toward others one to three days. The resident exhibited rejection of care behavior one to three days. The resident's functional status was total dependence for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #111 was observed in his room on 4/14/21 at 12:28 p.m. His lunch tray was on the bedside table. He was unable to lift his upper extremities. The resident had a straw/tube in his mouth for wheelchair movement. At 12:39 p.m. he left his room and wheeled down the hallway. Therapy staff talked to him in the common area. At 1:11 p.m., the resident went back down to his room. He told the staff he was ready when they were. Staff began to set up his tray at 1:22 p.m. The staff did not offer to reheat any of the food items which was observed for 52 minutes. The resident was interviewed on 4/14/21 at 1:55 p.m. He said there was nothing that could be done about the temperature of the food, until they got a warmer box. He said it took about five to 10 minutes to load the cart, then five to 10 minutes to wheel it to the hall, then another 10 minutes to unload the trays. He said the staff always left the cart door open. He said it took a long time to get assistance. He said the staff dropped his tray off in his room and told him they would come back. He said he did not like for them to place food in front of him without the ability to eat it. He said he had to look at the food for around 15-20 minutes. He said they would then give him the meal cold (cross-reference F804 palatability). Resident #111 was observed in his room on 4/15/21 from 12:25 p.m. to 12:55 p.m. The food cart was observed to have arrived at the hall at 12:25 p.m. The resident's lunch meal was observed on the bedside table at 12:45 p.m., untouched. One of the certified nurse aides (CNAs) told him his nurse was on break. Another CNA was observed helping his roommate with his lunch meal. The resident said his colostomy bag was leaking and wanted it fixed before he ate his meal. He told staff it needed to be fixed two hours ago. Staff came to fix his colostomy at 12:55 p.m. B. Resident #127 Resident #127, age 40, was admitted on [DATE]. According to the April 2021 CPO, diagnoses included anxiety, protein-calorie malnutrition, major depression disorder, type 2 diabetes mellitus, cerebral infarction, unspecified injury at C4 level of cervical spinal cord, type 1 diabetes mellitus and muscle wasting. The 3/8/21 MDS assessment revealed the resident had intact cognition with a BIMS score of 15 out of 15. The resident exhibited verbal behavior symptoms that occurred one to three days. Rejection of care was documented as occurring four to six days. The resident was extensive assistance for eating. Active diagnosis included: wound infection, cerebrovascular accident, quadriplegia and malnutrition. The care plan, initiated 4/15/21, revealed in part, The resident has ADL self-care, performance deficits related to quad status, muscle wasting, lack of coordination and multiple wounds. Interventions included: The resident requires extensive assistance by one staff to eat. The care plan, initiated 4/16/21, revealed in part, the resident has limited mobility related to contractures: bilateral hand contractures .Interventions included: the resident is totally dependent on staff for all locomotion/mobility. The resident was interviewed on 4/15/21 at 10:16 a.m. He said his meal intake depended on the meal. He said he felt the staff were upset about feeding him because he required assistance. He said the food arrived at 11:30 a.m. to 12:00 p.m. and they did not feed him until around 1:30 p.m. He said the food was always cold (cross-reference F804). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was observed on 4/19/21 for the breakfast meal. The meal cart was observed on the hall at approximately 8:18 a.m. The resident was out of his room, with his untouched meal tray on a bedside table inside his room, at 9:19 a.m. Staff were feeding him his meal at 9:41 a.m. The resident was interviewed at 10:30 a.m. He said the breakfast was cold and the staff heated up the oatmeal but the rest of the meal was served cold. He said breakfast was his favorite meal. He was observed to have eaten 100% his oatmeal, most of his bacon and some of the eggs. He said he tried to eat snacks but he required assistance. The resident was observed on 4/20/21 at 12:13 p.m. His lunch tray was in his room on the bedside table. The resident was noted without assistance at 12:30 p.m. C. Resident #95 Resident #95, age 39, was admitted on [DATE]. According to the April 2021 CPO, diagnoses included multiple sclerosis, depression, protein-calorie malnutrition, anxiety, pressure ulcer, functional quadriplegia and Parkinson's disease. The 2/15/21 MDS assessment revealed the resident had intact cognition with a BIMS score of 15 out of 15. The resident exhibited no behaviors. The resident was an extensive assistance with eating. The care plan, revised 10/20/2020, revealed in part The resident has an ADL self-care performance deficit related to multiple sclerosis, Parkinson ' s, functional quadriplegia, spastic movements, osteomyleitis of sacral and vertebra. Interventions included: eating- extensive assistance of one-sometimes may need dependency with feedings. The resident was observed on 4/13/21 at 12:36 p.m. She was seated at a table in the common area. She said she had been waiting 20 minutes for meal assistance. She had a large water pitcher on the table, away from reach. Her tray was on the table in front of her but she could not reach it. She asked a nurse to help feed her. A CNA came to the table for assistance at 12:41 p.m. The CNA left the area to get a clothing protector/towel. The CNA left and came back with a beverage at 12:45 p.m. She observed assisting the resident to eat her meal at 12:45 p.m. Staff finished assisting her with her meal at 12:59 p.m. The resident was observed asking who was going to take her out. The resident was observed on 4/14/21 at 11:59 a.m. The tray cart arrived at the hall at about 11:55 a.m. She raised her hand for assistance and asked for milk. Staff observed pushing a beverage cart around. At 12:05 p.m., a staff member brought her a hot beverage. Staff assisted her with her meal at 12:13 p.m. D. Staff interviews CNA #7 was interviewed on 4/15/21 at 1:32 p.m. She said if they had enough staff to pass trays, they would have time to assist the residents (cross-reference F725 for sufficient staffing). She said they passed out the trays first and then helped the residents. CNA#6 was interviewed on 4/15/21 at 2:01 p.m. She said if they had at least two people on the floor, then they could assist the residents with their meals (cross-reference F725). She said Resident #111 liked to have everything perfect before assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unit manager (UM) #1 was interviewed on 4/15.21 at 2:02 p.m. He said staff was informed by the nurse which residents required assistance. He said they did not pass the trays for the residents requiring assistance until the end. Licensed practical nurse (LPN) #2 was interviewed on 4/20/21 at 12:47 p.m. She said they passed out all the trays and then assisted the residents with their meals. She said she did not know how many residents needed assistance. CNA#5 was interviewed on 4/20/21 at 1:11 p.m. She said she helped pass out trays and got residents up in the morning. She said sometimes other staff would help pass the trays. She said there were two residents on the 900 hall that required assistance. She said they provided assistance after the trays were passed out. CNA #20 was interviewed on 4/20/21 at 2:07 p.m. She said they passed all of the trays first and then assisted residents with their meals. The director of nursing (DON) was interviewed on 4/20/21 at 2:29 p.m. She said she thought one person was assigned to pass the trays and one person was assigned to assist the residents. She said it was assigned to them by the UM. She said the team assisted in passing trays. She said they passed out the trays first and then assisted the residents. She said she would come up with a better process. 38503 III. Personal hygiene A. Resident #15 Resident #15, age 84, was admitted on [DATE]. According to the April 2021 CPO, diagnoses included cerebral palsy, thyrotoxicosis, hemiplegia, neuropathy and tremor. The 1/6/21 MDS assessment, revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She did not exhibit behaviors or reject care. She required extensive two-person assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident was observed on 4/12/21 at 5:41 p.m. She had facial hair above her lip and on her chin and her fingernails were very long with chipped nail polish. The resident was interviewed on 4/12/21 at 5:54 p.m. She said she would let the staff remove her facial hair and trim her nails if they offered. The resident was observed on 4/14/21 at 4:07 p.m. She had facial hair above her lip and on her chin and her fingernails were very long with chipped nail polish. The resident was observed on 4/19/21 at 8:50 a.m. Her facial hair was removed; however, her fingernails remained very long. B. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #14 was interviewed on 4/20/21 at 5:42 p.m. She acknowledged the resident's fingernails were long. She said the resident's fingernails should be cut when she was showered. She said activities would usually cut a residents fingernails when they polished nails in activities. The activities assistant (AA) was interviewed on 4/21/21 at 10:18 a.m. She said the activities department did not cut resident's fingernails they only painted resident's finger nails one to two times a month in activities and nursing was responsible to trim residents' nails. The assistant director of nursing (ADON) was interviewed on 4/21/21 at 5:38 p.m. He said the CNAs were responsible for ensuring the residents were groomed, including removal of facial hair and trimming of nails.

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F 0684 Level of Harm - 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** 43134 Based on observations, record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for three (#166, #118 and #146) of seven residents out of 68 sample residents. Resident #166 who was admitted on [DATE], with a known history and diagnosis of gastrointestinal (GI) hemorrhage (bleeding) and anemia was monitored closely for signs and symptoms of internal bleeding while being given anticoagulant medications. Resident #166 complaint of tarry stools and stools with bright red blood to RN#6 and was concerned regarding another GI hemorrhage given his history. The facilities failures to monitor and identify timely the signs and symptoms of internal bleeding to provide necessary treatment, lead to Resident #166 calling the ambulance himself and was transferred to the hospital. Resident #166 was pale upon admission to the hospital, had blood in his stool was diagnosed with gastrointestinal hemorrhage, his hemoglobin level was 7.1 and he transfused with one unit of PRBC (packed red blood cells) (see record review below). Furthermore, when RN#6 was informed of complaints of bleeding by Resident #166, her intervention was to give the resident a container so the stool could be visualized when he had another bowel movement. RN#6 failed to fully assess the resident at the time of his complaint or notify other staff for assistance as she was attending to another emergency situation with another resident. No vitals were taken, the physician was not notified of the status change for the resident, during shift report this information was not passed on to the oncoming staff, and Resident #6 never went back to check on Resident #6 before leaving. Moreover, the facility failed to have a person centered care plan or orders to effectively monitor for bleeding when Resident #166 and #146 were on anticoagulant medications. Additionally, the facility failed to: -Assess and document Resident#118's bowel condition following complaints of having constipation for several days; -Document a complete physician's order with the proper medication name, dosage, route and frequency in the resident's medical record, for a suppository administered to Resident #118; -Document the administration of a suppository given to Resident #118 on the resident's medication administration record; and, -Follow up on the results/effects of a suppository administered to Resident #118. Findings include: I. Professional references (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[NAME] A. M.; [NAME], H. from the National Center for Biotechnology Information (last update August 24, 2020) Gastrointestinal bleeding, Enhancing Healthcare Team Outcomes retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK537291/. It read, [NAME] (stool with blood) is dark, black, and tarry feces that typically has a strong characteristic odor caused by the digestive enzyme activity and intestinal bacteria on hemoglobin Care of patients with gastrointestinal bleeding requires coordinated and efficient interprofessional cooperation. Nurses manage the frequent monitoring of vital signs and more short-term interaction with and observation of patients. They must communicate their findings with the physicians, who use their own and nursing observations to make decisions for treatment. Multiple physicians may be necessary for treatment. General internists are typically responsible for the routine care of patients with GI bleeds A coordinated effort by all of these healthcare professionals functioning as an interprofessional team is necessary for early recognition and intervention in gastrointestinal bleeds to prevent further morbidity or mortalities. The measures to monitor a patient on blood thinning medications for abnormal GI bleeding include symptoms like change in bowel habits like diarrhea or melena, abdominal pain, retching or vomiting. Also to consider their history of prior GI bleeds, medications that can cause abnormal bleeding in the GI system. Laboratory values can be used to monitor a resident on these types of medications are, complete blood count hemoglobin and hematocrit, INR/PT/PTT if appropriate, lactate or liver function tests. II. Facility policy The Change in Condition and Physician and Family Notification policy was received by the assistant nursing home administrator (ANHA) on 4/20/21 at 10:00 a.m. It read in pertinent part, when a resident has a significant change in their physical status with an example of bleeding, the licensed nurse was required to contact the physician or designated on-call provider. Each attempt required to be charted in the resident's record with information about the provider, what they said and what information was given to that provider. III. Resident #166 A. Resident status Resident #166, age 64, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included amputations of two left toes, peripheral vascular disease, Osteomyelitis (bone infection) of right ankle and foot, diabetes, gastrointestinal hemorrhage, melena, atrial fibrillation, chronic obstructive pulmonary disease, anemia, coronary artery disease with surgery of the circulation system. The 4/15/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. He required supervision with setup for transfers, walking, eating and personal hygiene and one person assistance with bed mobility, dressing and toilet use. The MDS further documented a health condition for internal bleeding, he received anticoagulant medications. B. Resident interview (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #166 was interviewed on 4/12/21 at 4:09 p.m. He said he alerted registered nurse (RN) #6 on 4/4/21 about 5:30 p.m. that he had blood in his stool. He said his stools were black and tarry for the past three days before his last bowel movement that day (4/4/21) which had red blood in it and he was concerned. He said RN #6 asked him to use a hat in the toilet to collect his stool so she could assess it because he had flushed the one he reported to her. He said he did not hear from the nurse for almost an hour. He said he felt worried and angry about the bleeding as if the facility staff did not care, so he called an ambulance to go to the hospital. When he arrived at the hospital, he was given a blood transfusion and admitted for four days for monitoring. C. Record review On admission to the facility it was documented in the resident's record that he had a history of a GI bleed and there was no order to monitor him for abnormal bleeding in place. The resident's electronic medical record (EMR) during his initial stay at the facility (3/31/21 to 4/4/21) did not include laboratory results. -Additionally, there was no care plan in place to monitor for bleeding until 4/12/21 after the resident was transferred to the hospital (see below). The 4/2/21 nurse practitioner admission summary documented the resident had a history of a GI bleed with a required surgical intervention to place a clip on a duodenal visible vessel. It further documented in his history the resident had anemia, cardiovascular surgery and was placed on three medications for blood thinning, Plavix, Aspirin and Lovenox injection. The April 2021 physician orders for Resident #166 revealed orders were initiated on 3/31/21 for; -Aspirin 81 mg (milligrams) by mouth one time a day for pain; -Clopidogrel Bisulfate, 75 mg, give one tablet by mouth one time a day; -Enoxaparin Sodium Solution 40 mg/0.4ml inject 40 mg subcutaneously at bedtime for anticoagulation. These medications were ordered upon his first admission to the facility. The progress note by LPN #4 on 4/4/21 at 9:50 p.m. revealed, Resident #166 was not in his room after he went to the resident's room to administer scheduled medications. He notified the unit manager and a search was initiated. Later that evening the unit manager cancelled the search because the resident's location was known (the resident had transferred himself to the hospital). The progress note by RN #6 on 4/5/21 at 6:21 a.m. as a late entry read, Resident #166 notified her he had black stool so she gave him a hat to put in his toilet to collect stool and he said he knew how to collect the sample. In her assessment he denied other abnormal bleeding and his general appearance was ok. -There was no documentation that the resident's vital signs were taken, the physician was notified, or the resident had been transferred or requested to go to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The hospital records for his stay from 4/4/21 to 4/9/21, were retrieved from the resident's electronic chart on 4/14/21. It revealed that on 4/4/21 for Resident #166 began to receive treatment at the hospital facility at 6:38 p.m. -At 6:47 p.m. the occult blood stool sample taken at the hospital which was positive. -At 7:10 p.m. the emergency room doctor's progress note read, the resident had a low blood count for hemoglobin of 7.1 and hematocrit of 21.7. He was actively bleeding and ordered to give the resident a transfusion of packed red blood cells (PRBC) with his current condition, as well as Pantoprazole infusion through his IV (Intravenous) to help stop the stomach bleed. -At 7:27 p.m. in the resident's history given to the emergency room doctor, it read he said he started to feel abdominal pain, felt dizzy and lightheaded with melana for two to three days. The doctor wrote the resident had a pale color to him. The emergency room doctor documented that the resident needed to have a blood transfusion because his hemoglobin was less than eight with a history of coronary artery disease, had a recent stent placed and had received blood transfusions in his past. Review of the medication administration record (MAR) revealed an order to monitor for abnormal bleeding which was originated on 4/12/21 upon return from his hospital stay from 4/4/21 to 4/9/21 (this was 13 days after his original admission on 3/31/21). The history and physical dated of the encounter on 4/12/21 by the Physician read, the resident had a short hospital stay because he had melena for two to three days and was treated for a GI hemorrhage. In November of 2020, the resident had a hospital stay for a surgical intervention for coronary artery disease with a stent placement. The care plan focus area for anticoagulant and antiplatelet therapy, was initiated on 4/12/21 (after his admission to the hospital see original admitted [DATE] above) related to the resident's history of a GI bleed. Interventions included, to monitor the resident's vital signs and notify the provider of significant changes, monitor for discolored urine, bright red blood or black tarry stools and other signs of abnormal bleeding. -The resident said he wanted to be involved in making his health care decisions. Based on the experience with his medical history, he described what he knew to look for in his stools and other symptoms. D. Staff interview Registered nurse (RN) #11 was interviewed on 4/20/21 at 3:30 p.m. He stated resident's are monitored for signs of abnormal bleeding when they were first admitted or when they began a medication that was a blood thinner. The orders were used to identify resident's medications and what to monitor them for. When a symptom was identified, nurses obtained vital signs and performed an assessment and needed to notify the findings to the unit manager, the DON and the physician or designated provider to receive orders. The provider provided the next steps in the resident's care and documented the interactions and interventions made. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #12 was interviewed on 4/20/21 at 3:40 p.m. She said, the signs of bleeding to watch for are blood from vomiting like coffee grounds, and from the genital areas and bruising. Then she would notify the doctor and obtain orders for next steps. RN #6 was interviewed on 4/21/21 at 2:00 p.m. She said Resident #166 came to her about having black/tarry blood in his stool on 4/4/21 at about 5:30 to 6:00 p.m. She said she told the resident she needed to collect a stool sample for a visual assessment. She said she gave the resident a hat to place in the toilet which he took to place in the toilet himself. She said she did not receive a report (at the beginning of her shift) that he had blood in his stool or that he had a prior gastrointestinal (GI) bleed that required a procedure in October of 2020. She said she had another emergency she needed to attend to at the time Resident #166 notified her of his concern but he did not look to be in acute distress so she went to care for the resident who had the emergency. She said the certified nurse aide (CNA) reported to her about 5:45 p.m. the resident refused his dinner and was angry. She said she did not follow up with the resident about his concerns before the end of her shift and she did not complete an assessment of the resident to include vital signs or notify the physician. -She said there were two CNA's scheduled for the evening shift 2:00 p.m. until 10:00 p.m., but from about 4:00 p.m. until the end of her shift at 6:30 p.m. one CNA had to cover both (rapid recovery and 100) hallways. cross-reference F725 sufficient nursing staff LPN #4 was interviewed on 4/23/21 at 3:05 p.m. He said one nurse was usually scheduled for the rapid recovery unit and one nurse for the 100's hallway from 6:00 p.m until 10:00 p.m. He said on 4/4/21 he worked both the rapid recovery unit and the 100's hallway from 6:00 p.m. until 6:00 a.m. He said he cared for residents that required tracheostomy care, IV administered antibiotics and two person care. He said that there was one CNA that worked those two hallways when usually two cna's were scheduled. He said he did not receive any information Resident #166 complained of blood in his stool in a report from the offgoing nurse on 4/4/21. He said he was told by the offgoing nurse that he refused his supper. -He said on 4/4/21 at 9:50 p.m. he went to administer medications to Resident #166 and he was not in the room. He and other staff members searched the inside and outside of the premises for the resident and did not find him. He notified the supervisor who began a rapid search for the resident, and found out at around 10:30 p.m. the resident was at the hospital and needed to be admitted . The director of nursing (DON) was interviewed on 4/22/21 at 8:45 a.m. She said Resident #166 was a high risk for bleeding related to three medications that can cause abnormal bleeding. She acknowledged the resident did not have any orders or care plan to monitor for abnormal bleeding prior to calling an ambulance for himself due to having blood in his stool. She said staff were supposed to monitor residents on anticoagulant therapy and notify the physician for any change in condition. The nursing home administrator (NHA) was interviewed on 4/22/21 at 8:50 a.m. She stated Resident #166 used his rights to leave the facility, find a means of transportation to another facility and to seek treatment for himself. She felt RN #6 responded appropriately to his reported concern of bleeding. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	However, based on the resident's interview, the hospital report and the nurse caring for the resident, the resident's vitals were not taken, and the doctor was not notified of the change in status for the resident. The resident was pale in color upon arriving at the hospital and required urgent services. The facility failed to monitor a resident with a history of GI bleeding and respond appropriately as RN #6 who was caring for the resident stated she had another emergency situation she needed to take care of at the time Resident #166 voiced his concerns of bloody stool. III. Resident # 146 A. Resident status Resident #146, aged under the age of 60, was admitted on [DATE]. According to the April 2021 CPO, the diagnoses included, respiratory failure with a tracheostomy, congestive heart failure, morbid obesity, deep vein thrombosis right arm, pressure ulcer on heel, muscle weakness, hypertension and hemoptysis (coughing up blood from lungs). The 3/23/21 MDS assessment revealed the resident was cognitively intact with a BIMS of 15 out of 15. He required extensive assistance with one person for bed mobility, dressing, and toilet use. He required supervision with one person to assist in transfer and personal hygiene. He needed supervision while eating and walking in his room, on the unit and locomotion off the unit. He required oxygen therapy, tracheostomy suctioning and care and used physical and occupational therapy. C. Observations On 4/12/21 at 2:20 p.m. Resident #146 was wheeled out of his room on a stretcher pushed by two emergency personnel. He had blood that was on and around his tracheostomy. RN #6 stated the resident expelled a large clot from his tracheostomy and was sent to the hospital to help with thick secretion suctioning and to stop the bleeding from his lungs. On 4/13/21 at 8:40 a.m. the resident laid in bed at a 45 degree angle, with his tracheostomy open without a speaker valve, or trach collar over the opening to administer heated oxygen. He had a nasal cannula in his nostrils that administered oxygen through his nose. On his bedside table, the inner cannula to his tracheostomy was laid on his bedside table with a moderate amount of dried blood in and outside of it. The respiratory therapist (RT) assisted him to sit on the edge of the bed. His tracheostomy was suctioned with a blood clot that expelled out along with thick blood tinged mucus. The RT educated the resident about the heated humidity. D. Resident interview Resident #146 was interviewed on 4/13/21 at 9:15 a.m. He said after he returned from the hospital, he had a hard time breathing with the inner cannula in place with his tracheostomy because it was plugged up. -He also stated that the day he started bleeding from his tracheostomy, the nurse was suctioning him and he felt like a pop, and it hurt a lot. E. Record review (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #146's care plan revealed no monitor for bleeding even though the resident was on anticoagulant therapy. Review of the April 2021 CPO and MAR revealed there were no orders to monitor for abnormal bleeding while the resident was receiving anticoagulant therapy. The April 2021 orders for resident #146 read that he was receiving an anticoagulant medication, Xeralto, once a day for blood clot prevention from when he was admitted on [DATE] until an order on 4/8/21, was placed to stop the anti-coagulation medication in an effort to stop the bleeding from his lungs. -The orders did not include monitoring for abnormal bleeding when he received the anticoagulation medication for 23 days while he was at the facility. The hospital records for his stay from 3/27/21 to 3/31/21, were retrieved from the resident's electronic chart on 4/12/21. It read in pertinent part, the resident was sent to the hospital because he had blood in his tracheostomy secretions. His discharged diagnoses included that the bleeding from his tracheostomy was a result from trauma while suctioning tracheostomy. F. Staff interviews The RT was interviewed on 4/13/21 at 8:45 a.m. He stated the resident needed aggressive suctioning when he arrived that morning because there was a lot of thick mucus and blood clots that were difficult to expel by the resident spontaneously. The resident began to bleed through his tracheostomy from suctioning about two weeks prior. In an effort to control the bleeding the anticoagulant medication was stopped. The machine for ventilation was replaced two times and would be replaced again because the resident stated it was only put out cold humidity. The RN's provide deep suctioning while RT is not in the building, and RT is available on call as needed. RN #3 was interviewed on 4/15/21 at 1:00 p.m. He stated that when he had suctioned the resident and had a difficult time, he had to suction the resident tracheostomy deep and vigorously. Physician #3 was interviewed on 4/15/21 at 3:00 p.m. He said the resident was in a difficult situation because he was bleeding from his tracheostomy. It resulted from deep and vigorous suctioning, and continued because the tissue area of the lungs were sensitive, he was on an anticoagulant medication and he did not use his recommended tracheostomy collar with heated humidification because the ventilation machine only put out cool humidity, and had been replaced two times. The DON was interviewed on 4/22/21 at 8:45 a.m. She said all residents that had orders to take anticoagulation or antiplatelet medications are required to have an order and care plan to monitor for abnormal bleeding and to notify the doctor of any changes or complications related to those medications. cross-reference F656 develop/implement comprehensive care plan. 41032 IV. Failure to assess a Resident #118 for constipation and document physician orders A. Facility policy (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Medication Orders policy, dated November 2014, was provided by the assistant nursing home administrator (ANHA), on 4/20/21 at 5:58 p.m. It read in pertinent part: A current list of orders must be maintained in the clinical record of each resident. Orders must be written and maintained in chronological order. -When recording orders for medications, specify the type, route, dosage, frequency, and the strength of the medication ordered. -When recording a PRN (as needed) medication specify the type, route, dosage, frequency, strength and reason for administration. The facility Bowel Management Protocol, undated, was provided by the nursing home administrator (NHA), on 4/20/21 at 8:35 a.m. It read in pertinent part: In the absence of a bowel movement for three consecutive days the following will be implemented, a licensed nurse will assess the resident for: -Bowel sounds (if no bowel sounds - call the doctor); abdominal distension; pain and tenderness; digital exam to check for the presence of stool; vital signs; review meal intake. -A licensed nurse will initiate milk of magnesia, if no response within eight hours - initiate dulcolax suppository. If no response to the suppository within eight hours-initiate fleets enema and call the physician. -The resident will be monitored every shift to monitor effectiveness of treatments B. Resident status Resident #118, age 80, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included constipation, gastro-esophageal reflux disease (GERD), and dementia with behavioral disturbance. The 2/26/21 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) of 11 out of 15. The resident was unable to balance and stead without staff assistance when transferring and walking. The resident was continent of bowel and needed supervision, cuing and encouragement when going to the bathroom with assistance getting on and off the toilet. C. Resident interview Resident #118 was interviewed on 4/13/21 at 2:52 p.m. Resident #67 said I don't feel too good. I've been constipated for seven days and I feel uncomfortable. The resident said she was given medication to facilitate a bowel movement but, nothing was working. Resident #118 was interviewed again on 4/15/21 at 9:42 a.m. Resident #118 said she is feeling better, was no longer constipated and was able to eat breakfast with no stomach discomfort. 3. Record review Progress notes documented the following pertinent information: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Nursing note dated 4/4/21 at 6:52 a.m. Resident requested miralax at 5:00 a.m., for bowel movement. The was no order for miralax on the April 2021 medication administration record (MAR) and no documentation of a bowel assessment or outcome of the resident's request. -Nursing note dated 4/12/21 at 12:44 p.m. Resident appears hypoxia after physical therapy session, oxygen saturation was percent on room air. Called the resident's physician, ordered chest x-ray and lab work STAT, oxygen at two (2) liters per minute via nasal cannula, titrate as needed. -Nursing note dated 4/12/21 at 2:01 p.m. (Written by licensed practical nurse (LPN) #15) Resident was given a suppository by a female nurse, monitor for efficacy. Resident also saw her physician. -Nursing note dated 4/19/21 at 10:11 a.m. Resident denies pain or constipation, stated she had a bowel movement this morning at 7:00 a.m. Resident declined PRN (as needed medication) for constipation and voiced feeling tired. Physicians visit note dated 4/12/21 revealed the facility nurse request the residents physician see Resident #118 for decreased oxygen saturation levels. There was no documentation of concerns for constipation in the physician's note. The note read in pertinent part: -History of present illness: nurse reports oxygen saturation dropped to 88% on room air. Patient denies chest pain or shortness of breath .Examination: Patient alert, calm and cooperative with exam, no acute distress, no respiratory distress, lungs clear to auscultation. Psychiatry: no anxious affect .abdominal active bowel sounds, non-tender. The April 2021 medication administration record (MAR) revealed the resident did not have any prescribed medication to treat constipation. -There was no documentation of a suppository being administered to Resident #118 as documented in the resident's progress note dated 4/12/21 at 2:01 p.m. The MAR documented orders to track side effects for prescribed antidepressant, antipsychotic medications, constipation was one of the listed side effects. -The record did not indicate signs or symptoms of constipation through the month, from 4/1/21 through 4/14/21. The resident's bowel tracking record was reviewed for bowel movement results from 4/4/21 through 4/14/21. The record revealed the resident had one medium bowel movement on 4/4/21 and two bowel movements averaging a medium size every other day from 4/5/21 through 4/14/21. All bowel movements were described as being formed and of normal consistency. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The resident's medical record failed to document a full bowel assessment of the resident's gastrointestinal condition or results of the bowel tracking record related to the resident's complaints of constipation. There was no documented order for the administration of the suppository mentioned in a nursing note dated 4/12/21 at 2:01 p.m. and no documentation of what type of suppository was given or the result/effect of the suppository given. Furthermore, the resident's care plan documented the use of miralax, which the resident was previously prescribed but had since been discontinued months prior to this episode. Miralax was not indicated as part of the bowel management protocol. The resident comprehensive care plan revealed a care plan focus for constipation last updated 1/28/21. The care focus read in part: -Resident #118 is at risk related to alterations in bowel elimination constipation and diarrhea. Receives Miralax (polyethylene glycol). Interventions: encourage increased activity; encourage intake of fluids; evaluate bowel sounds as indicated and report significant abnormalities to resident's physician; refer to dietitian for consultation as indicated or dietary interventions and restrictions. -Resident #118 has the potential for constipation related to use and side effects of medication. Goal: Resident will have a normal bowel movement at least every third day. Interventions: follow facility bowel protocol for bowel management; increase fiber and fluid intake to provide more bulk in diet; monitor medications for side effects of constipation. Keep physicians informed of any problems; monitor, document, report signs and symptoms of complications related to constipation; record bowel movement patterns each day. 4. Staff interviews Licensed practical nurse (LPN) #9 was interviewed on 4/15/21 at 2:43 p.m. LPN #9 said if a resident complained of constipation or showed signs and symptoms of constipation the nurse should assess the resident for bowel function and check the daily bowel movement tracking record. If the resident had not had a bowel movement in three days the nurse would administer medication, as ordered. If the resident was not prescribed medications to treat constipation, the nurse would have to contact the physician to report the resident's bowel status and request treatment orders. Registered nurse (RN) #4 was interviewed on 4/10/21 at 10:04 a.m. RN #4 said Resident #118 had not made any complaints of constipation that she was aware of. RN #4 checked the resident bowel tracking record and said according to the bowel tracking the resident was having regular bowel movements. Resident #118 sometimes had delusions and would say she was experiencing constipation when she was not. If Resident #118 made complaints of constipation, the nurse should follow the bowel management protocol and assess the resident bowel status. Unit manager (UM) #2 was interviewed on 4/19/21 at 11:57 a.m. UM #2 said there should be a physician's order for any medication administered to a resident; and the order and administration of the medication should have been documented on the resident MAR. The UM was not sure why the order and administration of the suppository, documented in Resident #118's progress notes had not been documented on the MAR. The UM was unable to locate a written physician's order or telephone prescribing the administration of the suppository to Resident #118. The UM said she would contact LPN #15, the nurse who wrote the progress note, dated 4/12/21 at 2:01 p.m., to investigate what happened. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/19/21 at 12:07 p.m. The DON said when a resident complained of constipation the nurse was to follow the bowel management protocol procedure to determine necessary treatment needs. There should be a doctor's order for any medication administered to the resident and there should be a record of all prescribed medications to the resident. The nurse was to document administration of medications immediately following the delivery of the medication. The DON did not know why the order and administration of the suppository was not documented. UM #2 was interviewed on 4/19/21 at 5:10 p.m. The UM said she contacted LPN #15, and discovered form LPN #15 that he received a verbal order from the resident's doctor to administer a bisacodyl suppository to Resident #118. Due to resident preferences, he requested a female nurse give the suppository. He said he thought that nurse would enter and record the order and administration of the suppository into the resident's medical record. He was educated on correct procedure assessing a resident for constipation and for taking a physician's order. The physician's order for a bisacodyl was entered late into the resident's MAR on 4/19/21 at 12:00 a.m. A copy of a telephone order or the signed physician's order was requested of UM #2 on 4/19/12 at 5:20 p.m. UM #2 said she would look for the order but the order was never provided. The DON was interviewed on 4/20/21 at 9:26 a.m. The DON acknowledged there was no assessment of Resident #118's bowel status prior to or after administration of a suppository for complaints of constipation and there should have been. The DON said she conducted verbal education with the unit nurses and will continue education until all of the nurses were educated on expectation for bowel management.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on observations, record review and interviews, the facility failed to ensure one of six residents reviewed for pressure injuries (#127) out of 68 sample residents received care consistent with professional standards of practice. The facility failed to take steps to promote the prevention of pressure injury development, to promote the healing of existing pressure injuries, and necessary steps to prevent the development of additional pressure injuries for Resident #127. Resident #127 was admitted [DATE] with diagnoses of new quadriplegia and malnutrition. Record review revealed the facility was informed he entered the facility with a left lateral foot deep tissue injury (DTI) and a day later (2/4/21), knew he had a pressure area on his left gluteal fold. Record review, observation and interview revealed the facility failed to timely and adequately respond to his known risks in order to heal pressure injuries and to prevent additional skin breakdown. In the first two weeks of his admission, Resident #127's pressure injuries were not assessed, monitored or treated and pressure reduction measures were not implemented until 2/23/21. Further, while aware of the resident's poor intake as of 2/5/21, nutritional measures to promote healing were not implemented until 2/25/21. By this time, 22 days after admission, the resident had new pressure injuries - an unstageable left lateral foot injury and DTI right heel, both acquired 2/18/21, and an unstageable pressure injury to his sacrococcyx area (14 cm x 10 cm), extending bilaterally to both buttocks. Record review, interview and observation also revealed the facility failed to comprehensively and consistently address barriers to heal the resident's multiple pressure injuries and to prevent infection and new injuries from developing. As of 4/12/21, the facility had not developed a patient-centered care plan for skin integrity/pressure areas that identified and addressed the resident's resistance to repositioning (known as early as 3/2/21). Further, a nutritional intervention acceptable to the resident was not found until mid-April. Finally, observations during survey revealed the resident's heels were not consistently protected and his sacrococcyx injury was not treated as ordered. The resident's skin condition continued to decline; as of 4/20/21, the resident had six pressure injuries, including a sacrococcyx injury, classified as a stage 4, and a right buttock pressure injury and left lateral foot injury, both classified as unstageable. The facility's failure to recognize and promptly respond to Resident #127's pressure injuries and known risks for further injuries from 2/3/21 to 2/18/21, and failure to comprehensively address known barriers to healing thereafter, created the likelihood of serious harm if not immediately corrected. Cross reference: F656 (the facility failed to ensure care plans were implemented and updated as needed regarding skin conditions), F677 (the facility failed to ensure timely meal assistance) and F880 (the facility failed to ensure proper infection control procedures for wound treatments) I. Immediate jeopardy (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. Findings of immediate jeopardy On 4/19/21 at 12:20 p.m., it was identified that the facility failed to prevent pressure injury development for Resident #127. In the first two weeks of his admission, Resident #127's pressure injuries were not assessed, monitored or treated and pressure reduction measures were not implemented until 2/23/21. Further, while the resident's poor intake was identified 2/5/21, nutritional measures to promote healing were not implemented until 2/25/21. By this time, 22 days after admission, the resident had new pressure injuries - an unstageable left lateral foot injury and a DTI right heel, both acquired 2/18/21, and an unstageable pressure injury to his sacrococcyx area (14 cm x 10 cm), extending bilaterally to both buttocks that worsened to a stage 4 wound. Record review, interview and observation also revealed the facility failed to comprehensively and consistently address barriers to heal the resident's multiple pressure injuries. As of 4/12/21, the facility had not developed a patient-centered care plan for skin integrity/pressure areas that identified and addressed the resident's resistance to repositioning (known as early as 3/2/21). Further, a nutritional intervention acceptable to the resident was not found until mid-April. Finally, observations during the survey revealed the resident's heels were not consistently protected and his sacrococcyx injury was not treated as ordered. The resident's skin condition continued to decline; as of 4/20/21, the resident had six pressure injuries, including a sacrococcyx injury, classified as a stage 4, and a right buttock pressure injury and left lateral foot injury, both classified as unstageable. B. Facility plan to remove immediate jeopardy On 4/19/21 at 6:26 p.m., the facility submitted a letter to remove the immediate jeopardy. The plan read: Issue: Wound concerns identified on resident (#127) Resident specific immediate actions: 1. Resident (#127) wound was reassessed by the wound doctor on 4/12/21 and 4/19/21 to ensure appropriate treatment and care plan is in place. 2. Registered dietitian (RD) met with resident on 4/19/21 and reviewed his nutritional plan, discussing options to enhance nutritional interventions for wound healing. 3. Resident (#127) has positioning devices in place for bed and wheelchair (w/c) and is noted to frequently refuse use of devices to offload heels. The interdisciplinary team (IDT) will continue to encourage resident on need for proper positioning. 4. Facility IDT conducted a care plan meeting with resident (#127) on 4/19/21 and explained the risk and consequences of his non-compliance with nutrition and positioning. Systemic actions: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 4/17/21 and 4/18/21 a facility wide sweep was completed by nursing administration to evaluate skin integrity of residents and implement corrective actions as needed. The nursing admin team completed an audit of the skin system on 4/17/21 and 4/18/21 to ensure that weekly skin checks are current. The nursing admin team completed an audit of the Braden Scores on 4/17/21 and 4/18/21 to ensure that Bradens are up to date and interventions implemented accordingly. Braden risk assessments are performed on admission, weekly for 4 weeks, upon change of condition and weekly thereafter. A score of 10-12 is considered high risk and interventions are implemented accordingly. 2. Weekly skin checks will be monitored on an ongoing basis via review of the electronic medical record (EMR) during the stand up meeting. The accuracy of skin checks will be monitored by the director of nurses (DON) or designee via random weekly audits. 3. The nursing admin team ensured that all residents with wounds have appropriate interventions in place (such as pressure reducing mattress, cushions, RD consult) and their plan of care reflects those interventions. Audit initiated on 4/16/21 and completed 4/18/21 by licensed practical nurse (LPN) #13 and registered nurse (RN) #7. 4. Licensed nurses were inserviced by RN #2, RN #8, RN #9, LPN#13 beginning on 4/16/21 on: skin and wound care policy to include the importance of assessment and management of wounds and skin conditions; Braden risk assessments, identifying changes in integrity of skin and reporting those to medical doctor (MD)/DON/representative (RP), turning and positioning, notifications, pressure relieving surfaces and interventions, as well as how to add them if needed. The inservices were completed on 4/18/21, after which no nurse will be able to work without receiving the inservice above. 5. Inservices for certified nurse aides (CNAs) were done on 4/16/21 by RN#2, RN#8, RN#9 on turning and positioning, notification of nurse about new skin areas/dislodgement and soilage of dressing, change of condition, meal intake, notification of refusals, offloading, positioning and hydration. The inservices were completed on 4/18/21, after which no CNA will be allowed to work without receiving the inservice above. 6. Treatment nurse was inserviced by LPN#13 and RN #8 on assessment and staging, notification, implementing orders, interventions, admission assessment review, Braden scale risk assessment and completing wound reports. 7. A skin IDT meeting was held on 4/19/21 to review all current wounds and ensure plan of care is implemented. (IDT members: (names)). Monitoring: 1. DON or designee will monitor evaluations in point click care (PCC) to ensure wounds are evaluated and treatment implemented in a timely manner. Any issues identified will be corrected immediately. 2. DON or designee will complete random checks of wounds twice a week to verify that treatments are being performed as ordered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Wounds will be reviewed with the wound physician during the weekly wound rounds to monitor worsening, improvements, or infections for the wounds. Wound MD is notified of all wounds upon admission, when a new wound is noted, upon worsening and weekly during rounds. 4. All findings will be reviewed during weekly skin and wound meetings and compliance with this system will be reported to quality assurance and performance improvement (QAPI) committee monthly. Resident refusals of wound care, nutritional resources or pressure devices will be tracked during the skin and wound meeting via review of the medication administration records (MARs) and the IDT will identify alternative methods of addressing refusals such as educating the resident/representative on risk/consequence of refusal, offering alternatives and consulting with MD/extender for additional recommendations. Other: Attending physician for (resident #127), wound MD and medical director were notified of the imposition of immediate jeopardy findings as well as this plan of correction. C. Removal of immediate jeopardy On 4/19/21 at 7:00 p.m., the nursing home administrator (NHA) was informed the immediate jeopardy had been lifted at 6:26 p.m., based on the facility's implementation of the above plan. However, deficient practice remained at a G level, actual harm for Resident #127. II. Professional reference A. The NPUAP Pressure Injury Stages | The National Pressure Ulcer Advisory Panel - NPUAP. The National Pressure Ulcer Advisory Panel NPUAP. Web. (undated) http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages reads: A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence as a result of pressure, or pressure in combination with shear. The updated staging system includes the following definitions: -Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema. -Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. -Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. -Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar was removed, a Stage 3 or Stage 4 pressure injury will be revealed. B. According to the National Pressure Ulcer Advisory Panel (NPUAP), Pressure injury prevention points, updated 2016, revealed in part Consider bedfast and chairfast individuals to be at risk for development of pressure injury; Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within eight hours after admission); Use heel offloading devices .on individuals at high risk for heel ulcers. III. Facility policy and procedure Review of the Pressure Ulcer Prevention Program policy, reviewed 10/8/2020, provided by the NHA on 4/21/21 at 2:52 p.m. read in part All residents will be assessed for the risk of pressure ulcer development at the time of admission .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/Norton Scale. This will be done at the time of admission .If a pressure ulcer/skin breakdown is identified, the following will be done: the licensed nurse will complete a thorough assessment of the affected area; .the licensed nurse will notify physician and the family; treatment will be initiated per physician orders; the resident's care plan will be updated to reflect interventions; the interdisciplinary team will be notified so that appropriate referrals may be made .the licensed nurse will assess the area on a weekly basis .the DON will report results to the quality assurance/improvement committee on a quarterly basis. IV. Resident #127 A. Resident status Resident #127, age under 50, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included anxiety, protein-calorie malnutrition, major depression disorder, diabetes mellitus, cerebral infarction, unspecified injury at C4 level of cervical spinal cord, and muscle wasting. Review of the admission physician documentation, dated 2/11/21, revealed in part, Skin: warm and dry, no suspicious lesions .C4-5 spinal cord injury - patient wheelchair bound at this time .quadriplegia- as per above .Depression-severe at this time. Patient with severe trauma and change in overall status. Is now a new quadriplegic. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #127's record (set forth below) revealed the resident entered the facility on 2/3/21 with one deep tissue injury (DTI). As of 4/20/21, the resident had six pressure injuries: a left heel blister (acquired 4/12/21); an unstageable pressure injury to the right buttock (acquired 4/5/21); an unstageable pressure injury to the left lateral foot (acquired 2/18/21); a DTI to the right heel (acquired 2/18/21); a stage 4 pressure injury sacrococcyx extending to bilateral buttocks (2/23/21); and a DTI to the right plantar foot (acquired 4/20/21). B. Resident observations and interview indicated the facility failed to timely, adequately and consistently respond to the resident's pressure injury risk. The resident was observed and interviewed in his room on 4/12/21 at 2:19 p.m., 4/14/21 at 1:55 p.m., and 4/15/21 at 10:16 a.m. and at 11:23 a.m. On 4/12/21 at 2:19 p.m., the resident said he had a new pressure area, a bruise on his buttocks that he did not have when he arrived at the facility. On 4/14/21 at 1:55 p.m., the resident was seated in his wheelchair. His feet were in socks and his heels were pressed up against the wheelchair pedals. No pillow was underneath or behind his feet. On 4/15/21 at 10:16 a.m., the resident was seated in his wheelchair, again without a pillow underneath or behind his feet or any type of heel protection. He said the staff never offered a pillow for his heels. He said he had a big blister. When asked about nutrition (see diagnoses above), he said the facility had just started him on double meats for all meals about a week ago. He said he had tried previous supplements but did not like the taste. He said he had not tried any homemade milkshakes or fortified foods. He said his meal intake depended on the meal. He said he felt like the staff was upset about feeding him because he required assistance. He said the food arrived at 11:30- 12:00 p.m. and they did not feed him until around 1:30 p.m. He said the food was always cold. On 4/15/21 at 11:23 a.m., he was seated in his wheelchair. A pillow was underneath his heels. When interviewed at noon, he said he had to ask for a pillow and this was the first time they had placed a pillow underneath his heels. He also said he had a different mattress when he first arrived at the facility, but now had a special mattress. The resident was observed with a pillow underneath his heels throughout the remainder of the survey, indicating compliance. C. Record review 2/3/21 to 2/25/21, 3/1/21 to 4/12/21 and 4/12 to 4/20/21 confirmed the facility failed to timely and adequately identify and respond to known risks in order to heal pressure injuries and to prevent additional skin breakdown and failed to comprehensively and consistently address barriers to heal the resident's multiple pressure injuries to promote healing. prevent infection and prevent new injuries from developing. 1. 2/3/21 - 2/25/21 a. The facility failed to address a left lateral foot deep tissue injury (DTI) known on admission, failed to ensure appropriate follow up was completed for the pressure area identified on the left gluteal fold the day after admission, and failed to timely complete a comprehensive pressure injury risk assessment (Braden Scale). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital history and physical (H&P), dated 2/3/21, revealed in part, physical exam revealed C4/5 spinal cord injury .wounds present on admission: right shin-abrasion, left lateral foot - DTI, left clavicle-surgical, right shoulder friction, right chest tube and PEG tube. Review of the general nurse progress notes, dated 2/3/21, revealed in part Skin warm and dry. Dressing noted to right shoulder 2cm x 1.5cm superficial abrasion noted .Dressing noted to right shin 1cm wound scab noted without drainage .Resident able to move arms but hands are flaccid (soft and hanging loosely) . There was no documentation of the resident's DTI. Review of the admission nursing screener assessment, dated 2/4/21, revealed in part, the resident had an abrasion on left antecubital and the left lower leg. The resident was documented to have had a pressure area on the left gluteal fold. This assessment was signed off on 2/4/21. Yet, review of the weekly body check, dated 2/10/21, revealed the resident did not have any skin issues and the baseline care plan, signed 2/10/21, revealed skin risk was not marked for current skin integrity issues or history of skin integrity issues. Review of the weekly body check, dated 2/17/21, also revealed the resident did not have any skin issues. Review of the Braden Scale for predicting pressure injury risk, dated 2/17/21, revealed the resident was at high risk of developing pressure injuries with a score of 12 out of 23. This assessment was signed off on 2/25/21, 22 days after admission. Per facility policy, the Braden Scale was to be completed on admission (see above). b. Record review revealed new pressure injuries and the progression of moisture associated skin damage/stage 2 pressure areas (identified 2/17- 2/18/21) to an unstageable sarcococcyx injury, extending to bilateral buttocks as of 2/25/21. Review of the weekly wound observation tool, dated 2/17/21, revealed the resident had an acquired stage 2 pressure injury on right/left gluteal folds with a measurement 2 centimeters (cm) x 1cm x 0cm. This was documented as the first observation. The resident was documented as educated for repositioning while in bed. However, the resident was totally dependent and there was no care plan directing staff to assist in repositioning the resident. Review of the skin/wound progress note, dated 2/18/21, revealed in part Resident referred to wound care per nurse. Resident with scab to right subclavian and right calf area. Right heel with non-blanchable area. Left lateral foot with eschar. Small open area to right buttock and open area to left buttock .Dr (name) updated on wound status. Air mattress ordered. Heels offloaded. Resident complained of pain to shoulders and wound to left buttock . Review of the weekly wound observation tool, dated 2/18/21, revealed the resident had: -An acquired unstageable pressure injury to the left lateral foot (acquired 2/18/21) with a measurement of length (L) 2.4cm x Width (W) 2.0cm. No infection suspected. Treatment updated to include; heel off-loading, positioning and incontinence management. An air mattress was documented as ordered. -An acquired deep tissue pressure injury right heel (acquired 2/18/21) with a measurement of L-2.0cm x W-2.5cm. No infection suspected. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An admitted right calf wound- unknown, with measurement L-7.0cm x W-1.4cm. No infection suspected. -An admitted moisture associated skin damage to the left buttock with a measurement of L-1.0cm x W-1.0cm x depth (D) 0.1cm. No infection suspected. -An acquired moisture associated skin damage to the right buttock (acquired 2/18/21) with a measurement of L-4.0cm x W-1.7cm x D-0.2cm. Small serous drainage. No infection suspected. Pain associated with treatment. Notwithstanding the information above, review of the weekly body check, dated 2/19/21, revealed, in pertinent part, the resident had a small blister on the left index and middle finger. No other skin issues were documented. And, review of the nurse practitioner (NP) documentation, dated 2/19/21, revealed no mention of any pressure injuries. Further, there was no documentation the NP had been informed of the resident's pressure injuries. Review of the skin/wound progress note, dated 2/23/21, revealed in part Resident wound check noted left and right buttock combined with involvement to gluteal fold. Area measures L-8cm x W-4.0cm x D-0.2cm . Small bloody drainage to edges. No complaint of pain to the wound site .Right heel continued with maroon discoloration . Review of the weekly wound observation tool, dated 2/25/21 revealed the resident had: -An unstageable pressure injury to the left lateral foot (acquired 2/18/21) with a measurement of L-2.0cm x W-4.0cm. No infection suspected. Treatments updated to include: air mattress, heel off-loading, positioning, incontinence management and nutritional support. -A deep tissue pressure injury right heel (acquired 2/18/21) with a measurement of L-2.0cm x W-3.3cm. No infection suspected. -A right calf wound- trauma with measurement L-7cm x W-3cm. No infection suspected. -An unstageable pressure injury sacrococcyx extended to bilateral buttocks with measurement L-14cm x W-10cm. Small serous drainage. No infection suspected. Review of the PA (physician assistant) surgical notes, dated 2/25/21, revealed in part, Reason for visit: consultation and evaluation of wounds found on the sacrococcyx extending to the bilateral buttocks, right heel, right shin and left lateral foot .We are analyzing this patient for wounds located at the sacrococcyx extending to the bilateral buttocks, right heel, right shin and left lateral mid foot. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Patient has a wound on the right foot and buttock upon admission. This buttock wound has worsened. Wound #1: Sacrococcyx extending to the bilateral buttocks: unstageable .Muscle tissue debridement performed by surgical excision .Pre-op wound L-14cm x W-10cm x undetermined (UTD). The post op wound area was L-14.1cm x W-10.1cm D-0.4cm. First visit. Wound #2: right heel: rule out vascular/arterial .pre-op wound area was estimated to be L-2cm x W-3.3cm x UTD. First visit. Wound #3: right shin: trauma .pre-op wound area was L-7cm x W-3cm x UTD .wound edge necrotic. First visit. Wound #4: left lateral mid foot: Unstageable pressure injury .Pre-op wound area was measured at L-2cm x W-4cm x UTD .Calloused and necrotic wound edge. -First visit .The wound debrided today was at the sacrococcyx extending to the bilateral buttocks. For this wound, there was an indication of tissue decline which will entail continued management and will probably need future debridement. Healing of these wounds can not (sic) be guaranteed given the patient's diagnoses/risk factors that affect the healing progress of these wounds .Prognosis: feel the prognosis for this patient's sacrococcyx extending to the bilateral buttocks to be fair .Follow up: aggressive, weekly, follow up care is needed with debridement. c. Record review revealed the facility failed to timely implement an air mattress, off-loading interventions and nutritional interventions to promote wound healing prior to the progression of the left and right buttock wound (see above). Review of the April 2021 CPO revealed the resident was ordered for the following: -Air mattress, dated 2/23/21. -Encourage resident to off load buttocks with frequent position changes side to side with pillows or wedge every shift for wound care. Dated 2/23/21. -Encourage resident to off load heels by floating on pillows or booties when in bed every shift for wound care. Dated 2/23/21. Review of the nutrition/dietary note, dated 2/25/21 revealed in part (Resident) is agreeable to multivitamin (MVI) and prostat 30 milliliters (ml) BID between meals . Review of the April CPO revealed the resident was ordered to receive a regular diet with regular liquids and regular texture, dated 3/3/21. The resident was ordered to receive prostat supplement for wound care twice a day, dated 2/26/21 with a discontinued date of 3/5/21. 2. 3/1 to 4/12/21 Record review 3/1 to 4/12/21 revealed the facility failed to comprehensively and consistently address barriers to heal the resident's multiple pressure injuries and prevent infection and new injuries from developing. a. Record review revealed: Resident resistance to measures to relieve pressure and to improve nutrition; presence of infection and debridement of injuries; progression of sacrococcyx pressure injury to stage 4 wound; and the presence of new wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the skin/wound note, dated 3/1/21, revealed in part, Resident on bariatric air flow mattress, booties in room and offered. Resident prefers heels floated on pillows at present. Review of the nurses' note, dated 3/2/21, revealed in part, Resident decline(d) to reposition. Resident stated he was on his side for two days and he is going to stay on his back. Resident was educated . Review of the nurses' note, dated 3/3/21, revealed in part, Resident wound is draining and has a bad smell and different color. The wound was treated as ordered. Resident is on IV (intravenous) antibiotics with no adverse reaction noted at this time. The PA surgical notes, dated 3/4/21, revealed the resident's pressure injuries had decreased in size, Change in patient health: patient was started on IV antibiotics .He had a venous doppler done which revealed normal lower extremities. The arterial doppler is pending .Wound #1: Sacrococcyx extending to the bilateral buttocks .Muscle tissue debridement performed by surgical excision .pre-op wound area was L-13.8cm x W-9.8cm x UTD. The post-op wound area was L-13.9cm x W-9.9cm x D-2cm 100% slough .Wound has decreased in size .Wound #2: right heel .pre-op wound was L-1.6cm x W-3cm x UTD .Wound has decreased in size . Wound #3: right shin: trauma .pre-op wound area was L-7cm x W-2.6cm x UTD .wound has decreased in size .Wound #4: left lateral mid foot .unstageable .pre-op wound area was measured at L-1.8cm x W-3.5cm x UTD . wound has decreased in size .we consider the prognosis for the patients sacrococcyx extending to the bilateral buttocks to be poor: patient is noncompliant with offloading and is not eating well. Review of the skin/wound note, dated 3/4/21, revealed in part Encouraged resident to allow staff to turn frequently and off load heels. Resident stated that sometimes he doesn't want to turn. Resident requested to be in semi fowlers at 90 degrees. Educated that position is increasing pressure on wound. States that unable to operate phone .in this position. Review of the infection note, dated 3/6/21, revealed in part Resident continue(s) on IV antibiotics. Review of the skin/wound note, dated 3/9/21, revealed in part Spoke to resident to encourage frequent position changes when in bed, turning from side to side. States that he is doing that. Spoke with physical therapy (PT) concerning possible adaptive devices for phone, bed desk and TV. Discussed positioning challenges. Review of the NP documentation, dated 3/10/21, revealed in part, Patient being seen today for wound to coccyx area. Patient has required frequent change(s) to coccyx area due to increased drainage, patient being followed by wound nurse in the facility .Patient has multiple other wounds to his right shin right heel. Patient also has wound to left lateral foot that is healing. Patient with a history of bilateral shoulder pain, making it difficult for patient to reposition due to pain in bilateral shoulders .Assessment .chronic pain due to trauma .coccyx pain . Review of the weekly wound observation tool, dated 3/11/21, revealed the resident had: -An unstageable pressure injury to the left lateral foot (acquired 2/18/21) with a measurement of L-1.7cm x W-3.2cm. No infection suspected. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An admitted right calf wound- trauma with measurement L-6.6cm x W-1.5cm. No infection suspected. -An unstageable pressure injury sacrococcyx extended to bilateral buttocks with measurement L-13cm x W-9.5cm. Moderate drainage. Undermining present with 80% slough. Infection suspected - Yes. New swelling and undermining present. Added Bactroban. Review of the PA surgical notes, dated 3/11/21, revealed in part, Location: sacrococcyx to the bilateral buttocks, stage IV (4) pressure injury .pre-op wound area was L-13cm x W-9.5cm x UTD. The post-op wound area was L-13cm x W-9.6cm x D-6cm . wound has decreased in size .Location: right heel: pre op wound area was found to be L-1.5cm x W-3.0 cm x UTD .wound has decreased in size .Location: right shin ., pre-op wound area was evaluated to be L- 6.6cm x W-1.5cm x UTD .wound has decreased in size .Location: left lateral mid foot: unstageable .pre-op wound area was evaluated to be L-1.7cm x W-3.2cm x UTD .wound has decreased in size. Review of the nutrition/dietary note, dated 3/12/21, revealed in part (Resident) declines all supplements: med pass, Ensure, Magic cup, Juven, prostat .likes a grilled cheese sandwich at times and plans to order with a meal at times during the week . Review of the weekly wound observation tool, dated 3/18/21 revealed the resident had: -An unstageable pressure injury to the left lateral foot (acquired 2/18/21) with a measurement of L-1.7cm x W-3.2cm. No infection suspected. -A deep tissue pressure injury right heel (acquired 2/18/21) with a measurement of 0cm x 0cm. gNo infection suspected. Intact. -A right calf wound- trauma with measurement L-6.5cm x W-1.5cm. No infection suspected. -An unstageable pressure injury sacrococcyx extended into buttocks with measurement L-12.0cm x W-9.2cm. Moderate drainage. Undermining present with 40% slough. Infection suspected - Yes. Odor - Yes. Fever and foul odor were marked. -A second assessment was completed for the same day (3/18/21) for the sacrococcyx extended to bilateral buttocks with measurement L-13cm x W-9cm with no undermining and labeled as a deep tissue injury with 80% slough. Review of the physician documentation, dated 3/18/21, revealed in part, Reason for appointment: acute visit-fever; wound infection .Di[TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41032 Based on observations, record review and interviews, the facility failed to ensure three (#124, #8 and #137) of five residents with limited mobility received appropriate services, equipment and assistance to improve, maintain and/or to prevent further decrease in range of motion (ROM), out of 68 sample residents. Specifically, the facility failed to ensure: -Resident #124, #8 and #137 received consistent restorative nursing services per therapy recommendations, to manage assessed needs to improve, maintain, and or prevent possible loss of mobility; -The care plan, treatment administration record and task orders documented correct orders for splinting assistance for Resident #124 and restorative nursing services for Resident #124, #8 and #137; and, -Resident #124 received splinting assistance to protect skin integrity and prevent the possibility of worsening of a contracture. Findings include: I. Facility policy The Restorative Nursing Services policy, dated July 2017, was provided by the nursing home administrator on 4/22/21 at 8:10 a.m. It read in pertinent part: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. -Restorative goals and objectives are individualized and resident centered, and are outlined in the resident's plan of care. The Contracture Management Program protocol, dated 10/8/20, was provided by the NHA on 4/22/21 at 8:10 a.m. It read in pertinent part: Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion. -Residents will be assessed by a rehabilitation team member upon admission, readmission, quarterly, and when a significant change occurs for contractures or any decline of range of motion. -Possible treatments may include but not limited to splinting, ROM, and pain management. -Splinting order must be written correctly including: splint to be applied to what joint, which side, and for what reason. -A nurse must check skin prior to application and after removal of a splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Orders for range of motion to include the extremity and joint, number of repetitions, and whether weights are required. What type of range of motion to be provided (active, active assist or passive) and how often. -Any decline of significant change in range of motion must be reported and screened. -A resident will be seen by restorative nursing indefinitely to manage splinting and will not be discontinued unless the resident discharges. II. Resident A. Resident #124 1. Resident status Resident #124, age 86, admitted on [DATE]. According to the April 2021 computerized physician's orders (CPO), diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left dominant side; contracture of the muscle, left upper arm wrist and hand; pain; and dementia. The 3/4/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to participate in the brief interview for mental status (BIMS). Staff assessed the resident to have severely impaired memory recall abilities. The resident was conscious but was unable to respond to questions or make sound decisions. The resident did not reject care assistance and had total dependence on staff to complete all activities of daily living (ADL). The assessment documented the resident had impairment of the left upper extremity and no impairment of the lower extremities but was unable to stand or walk. -The assessment failed to document restorative nursing services or splinting assistance. 2. Observations On 4/13/21 at 8:33 a.m., Resident #124 was observed in bed with contractures at the left elbow, wrist and hand. The resident was not wearing a hand splint of any type. The left elbow was bent tight up against the upper arm, the left wrist was bent down towards the forearm and the fingertips rested directly on the palm of the left hand. The nails of the left hand were long, jagged, and imprinted into the bottom of the palm just above the wrist. The resident was observed at other times. On 4/13/21 at 9:35 a.m., and 12:02 p.m.; 4/15/21 at 8:58 p.m., 10:20 p.m., 11:21 p.m., 12:03 p.m., and 3:43 p.m.; 4/19/21 at 10:04 a.m., 11:33 p.m.,1:06 p.m., and 2:15 p.m Resident #124 was in the same position as described above without the use of splints and nails in the same long and jagged condition pressing into the skin. 3. Record review Background on contractures (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Occupation therapy (OT) treatment notes revealed Resident #124 was assessed for overall condition mobility and needs for medical equipment. The assessment dated [DATE], documented. The resident required total assistance with all ADLs and had contractures of the left upper extremities. The resident's left elbow was fixed at approximately 100 degrees and the left wrist was fixed at approximately 90 degrees. The residents right upper extremity active ROM was within functional limits. Recommendations were for a new program to include splints for the residents left elbow and wrist. OT assessment dated [DATE] read in pertinent part: Resident spends most of her time in bed and requires total assistance for all ADL's .Left upper extremity: Severe contractures throughout left upper extremity. Has elbow and palmar splint that nursing is applying. Right upper extremity. Therapy orders Splint orders note read: Elbow Splint to be applied by restorative aide (RA) for two hours post passive ROM/light stretching to prevent further contractures. Wrist/ hand splint to be applied at night and taken off when the resident wakes up. Splints should not be worn at the same time to prevent breakdown and additional pressure. Order dated 6/19/19. -OT note dated 9/27/19 revealed the resident was fitted for a left palm protector and posey finger separator. -Order note read: Place blue posey finger separator in between resident's left digits (fingers), as tolerated to promote skin integrity. Check skin frequently and remove if redness occurs. Use the provided palm protector instead of finger separator, if finger separator is not tolerated well. The resident was not observed to be wearing the blue posey finger separator or palm protector throughout day time hours and the order was not written on the resident's TAR or task orders. The January 2021, February 2021, March 2021, and April 2021 task records were reviewed the task records for all four months documented restorative nursing program orders. The orders were the same each month and read: Splint Program- Elbow splint to left elbow on for two hours as tolerated with total dependence assistance. Check skin before and after application and report any changes to the nurse. Provide PRN (as needed). -The only date the service that was documented as being provided over the four-month period was 1/22/21. Passive ROM program-passive ROM to bilateral upper extremities, upper elbows with light stretching with total dependence one person assist, two times with 12 repetitions. Perform program as tolerated. Provide PRN. -The only date the service that was documented as being provided over the four-month period was 1/22/21. Physician orders (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2021 CPO documented the following order: -Wash left hand and dry well, twice a day, trim nails, as needed. Report any skin changes to the physician. Active as of 6/12/2020. -Softpro left hand resting splint, two times a day. No directions specified for this order. Active as of 6/12/2020. -The CPO orders for splinting did not match the therapy orders for splinting assistance and did not show an order for the resident's prescribed splint to the left elbow or finger separator/palm protector. The order only documented the use of the resting hand splint and failed to document that the resting hand splint was to be used overnight at bedtime and removed upon waking. Because the hand splint order documented on the CPO was incomplete, and had no specific directions for use (duration, time of day, reason for use), and was listed as other type of order it did not transfer to the Resident #124's medication administration record (MAR) or treatment administration record (TAR). The March 2021 and April 2021 MAR or TAR failed to show the order for use of hand splints, or other restorative nursing services, to show that nursing staff were monitoring the resident for splint use, either duration or tolerance. Care plan The resident's comprehensive care plan revealed a care focus for presence of contractures. The care focus revised 3/22/21, read in pertinent part: -Resident #124 requires extensive total assistance with all ADL's. Resident does not walk, and has left sided deficits, contractures. Interventions: Apply Softpro resting splint to left hand two times a day (initiated 6/12/2020); nurse to keep nails short and filed (initiated 9/8/19); and wash left hand and dry well every shift, report any skin changes to physician (initiated 9/8/19). -Resident #124 has limited physical mobility related to contractures of bilateral upper extremities. Goal: Risks associated with contractures will be minimized. Interventions: Elbow splint to left elbow (initiated 4/16/21 during survey); keep nails short and filed, to be done by a nurse (initiated 11/27/19); monitor, document, and report any signs of symptoms of immobility: contractures forming or worsening (initiated 11/27/19); and provide gentle range of motion as tolerated with daily care (initiated: 11/27/19). The April 2021 visual bedside kardex report read in part: Resident care: passive ROM program- passive ROM to bilateral upper extremities, upper elbows with light stretching with total dependence on one person assist, two time a day with 12 repetitions. Perform programs as tolerated. Provide gentle range of motion as tolerated with daily care. The kardex did not show an order for the resident's prescribed splint to the left elbow. Other (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Therapy Screenings dated 11/19/20 and 3/1/21 documented Reason for therapy screen: care plan update. Screen findings: upper/lower extremities splinting and bracing adaptive equipment. Prior MDS assessments (dated 6/9/2020, 8/8/2020 and 12/4/2020) failed to document the resident's needs for restorative nursing services and splinting assistance. The resident's progress notes were reviewed from 12/20/20 through 4/7/21. There was no mention of the status of the resident's contractures, tolerance of splinting or restorative nursing services. 4. Follow up for status of Resident #124's contractures OT visit note dated 4/20/21 read in pertinent part: This OT following up on previous OT assessment in regards to worsening contractures on left upper extremities to determine appropriate plan of care. -Resident #124 was provided a Neuro-flex elbow splint and resting hand splint and placed on a restorative nursing program, in beginning of 2019 to address contractures due to history of a stroke. -At rest resident has severe elbow and wrist contractures. Resident had no active movement of the left upper extremity. This OT was able to passively withhold and release stretches and get her hand to tolerate a carrot for 40 minutes while OT was present. This OT was able to minimally stretch wrist with this OT having to hold wrist to maintain positioning. This OT placed a rolled washcloth in between wrist and fingers to assist in maintaining position. With hold and release stretches and mild massage this OT was able to achieve approximately 70 degrees of elbow extension. Immediately upon releasing, the resident's elbow returned to previous positioning. -This OT also stretched also stretched the right upper extremity to assess for contractures. Resident does have active movement in the right upper extremity. Resident would not allow movement at the shoulder. With assistance and tactile cues resident demonstrates ability to complete approximately 130 degrees elbow extension and ability to open and close digits. Resident's resting position appeared to be in elbow flexion and gripping onto the sheet with her right hand. -Patient would benefit from stretching of the left upper extremity to prevent further contractures and skin breakdown as well as active assisted stretching on the left upper extremity to prevent contractures and encourage movement. -Resident to be placed on skilled OT two times a week to address contracture management strategies and splinting alternatives as resident contracture has been long term. Skilled OT to occur for two to three weeks and then transition to restorative therapy provided by the facility. Resident #124 was observed on 4/21/21 at 12:15 a.m. The resident was being assisted to eat her lunch and she had a soft carrot palm splint in her hand. Certified nurse aide (CNA) #10 said the nurses provide the splint for resident use this week and was to wear the splint as tolerated until new orders were placed. D. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #9 was interviewed on 4/19/21 at 1:22 p.m. LPN #9 said the nurses were responsible to apply resident splints and make sure the resident was tolerating the treatment. The CNAs could reapply the splints if it had to be removed for care. The RA's were responsible for assisting the resident with other restorative nursing services including active and passive ROM, walking, and other services to assist a resident in building functional abilities with ADL's. The RA working today was reassigned to work as a CNA, this happens often. When the RAs get assigned to work as a CNA and they are not able to complete all prescribed restorative services. Restorative aide (RA) #7 was interviewed on 4/19/21 on at 1:38 p.m. RA #2 said she got pulled from her regular duties as a restorative aide to work the floor as a CNA, due to CNA shortages. Because she was tasked with performing the duties of a CNA she was not able to complete restorative program duties for the resident's on the second floor halls. This had been occurring since last April 2020 when the COVID-19 pandemic started, and the pandemic caused the facility to be short of CNA's. RA#7 said Resident #124 was not receiving the restorative nursing program because of insufficient staffing and the inability to have the Resident's OT provider come into the building to reassess the resident splinting and restorative program. The OT provider was unable to enter the facility due to COVID-19 visitor restrictions. RA #7 did not know details of why the resident was not receiving splinting assistance, only that Resident #124's restorative program was old and could not be resumed until the resident was reassessed. The CNA continued to assist the resident with ROM with daily ADL care. The minimum data set coordinator (MDS) was interviewed on 4/19/21 at 2:16 p.m. The MDS said information entry into the MDS assessment came from resident observation, assessment of functional ability and data provided to her from other facility department managers. It had been a long time since the MDS received any information on delivered services for the restorative nursing program. The facility was not billing for restorative nursing or adding it to any resident's MDs because the facility CNAs were providing ROM with daily ADL care. LPN #10 was interviewed on 4/19/21 at 3:40 p.m. LPN #10 said she does not work regularly with Resident #124 and had not been assigned to the residents care for a few weeks. LPN #10 remembered the resident had an order to wear a hand splint in the morning and the evening nurse removed them. LPN #10 did not remember the resident wearing a splint at night. LPN #10 looked at the resident's treatment orders, but was unable to locate an order for splinting assistance. LPN #10 assessed the residents left arm and hand. The LPN was able to open the resident's hand enough to look at the resident's palm. The palm of the resident's hand where her nails rested had a small red mark relieved when the nails were removed from resting on the palm. The LPN acknowledged the resident's nail needed to be trimmed to protect skin integrity and said she would cut them later this evening. The rehab director (RD-COTA) was interviewed on 4/20/21 at 1:51 p.m. The RD-COTA said the Resident #124's current restorative program was recorded in the task section of the resident's medical record. Any current session provided would be recorded in the task record. The resident's OT and PT provider were outside vendors from the resident's physician's office. The OT and PT enter the facility to assess the resident's rehabilitation needs and provide us with order to follow out the prescribed treatments. Resident #124 was prescribed splinting for contractures and passive ROM activities. The RD-COTA acknowledged that the orders for restorative nursing and splinting assistance was not correctly documented in the resident's record of the TAR and task record. The failure came as they transitioned from paper orders to electronic medical record orders a few weeks ago. The resident's restorative services should not have been listed as PRN. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43134 III. Resident #137 A. Resident status Resident #137, age 60, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), the diagnoses included traumatic brain injury, respiratory failure with hypoxia, cerebrospinal fluid drainage device, hydrocephalus, tracheostomy, gastrostomy, intracerebral hemorrhage, persistent vegetative state, late onset of Alzheimer's disease, seizures, diabetes. The 3/15/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of zero out of 15. He is in a vegetative state, unable to answer for himself. He required total assistance from one person with eating. He required total dependence from two or more staff with bed mobility, toileting, personal hygiene, dressing and transfers. He required care for an indwelling catheter, tracheostomy care and included oxygen delivery, suctioning, and ventilation, as well as a feeding tube that he completely depended on for nutrition and hydration. B. Record review The 3/2/21 hospital discharge record revealed the resident had diagnosed contractures of both his hands and was not able to move his hands independently. The care plan initiated on 3/11/21 and last revised on 4/13/21 had interventions to limited physical mobility related to neurological deficits; Provided gentle range of motion and passive range of motion program. -It did not include a specific focus area with the specific cares and goals according to the restorative therapy plan made by the therapy department. The April of 2021 resident's orders were reviewed and did not reveal orders for restorative program care areas as planned by the therapy department. The generic restorative plan initiated on 4/9/21 for Resident #137 was received by the director of rehab (RD-COTA) on 4/20/21. It read in pertinent part to, the resident was discharged from physical and occupational therapies and required restorative therapy to decrease the risk of contractures (see RD-COTA interview below). Upon discharge from therapy, the restorative program was to provide the resident planned goals for passive range of motion (PROM) for six to seven days a week to decrease the risk or worsening of contractures. As well as, to transfer into a wheelchair two times a day for six to seven days a week to promote upper body alignment. The form also read, Restorative plan and restorative order should reflect the above data. Upon discharge this form should be provided to the Restorative Nurse Manager and Restorative Nurse Aide for the initiation of Restorative Care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2021 restorative program tasks for Resident #137, revealed the resident received PROM was documented three times and transferred to a wheelchair to sit two times a day was documented four times from 4/9/21 until 4/20/21. C. Interviews The minimal data set (MDS) nurse was interviewed on 4/14/21 She stated that she is the MDS nurse that works virtually to complete the resident's assessments and used the electronic medical record to complete the MDS for the resident ' s. She said, the restorative care plans were behind including the restorative care plan and documentation was not completed for most residents. Restorative aide (RA) #3 was interviewed on 4/19/21 at 1130 a.m. He stated that he is one of the restorative nurse aides that works on the El Dorado unit. He works at least two days per week on the floor as a CNA, if not more often. When he works on the floor that often, he is not able to provide the restorative therapy the resident's need. Cross-reference F725 RA #7 was interviewed on 4/19/21 at 1:30 p.m. She stated that she had four shifts a week and was a restorative aide. She worked as a CNA on the floor three to four times a week in place of providing restorative program care. Another restorative aide that works with RA #7 worked at the facility Tuesdays through Fridays and worked as a CNA unable to provide restorative program needs as well. The RD-COTA was interviewed on 4/20/21 at 1:30 p.m. She stated Resident #137 had Physical and Occupational therapy for his first 30 days at the facility. When he met his maximum potential for rehabilitation he was discharged from PT and OT on 4/9/21 and restorative therapy was ordered and initiated on 4/9/21. The assistant director of nursing (ADON) was interviewed on 4/21/21 at 4:35 p.m. He said the resident's passive range of motion (PROM) was an incorporated task in the electronic medical record (EMR) and completed by the CNA ' s. The director of nursing (DON) was interviewed on 4/21/21 at 4:35 p.m. She said the ADON was appointed to the position as the restorative program nurse about two months prior. The administration team had identified the restorative program had problems because the restorative aides were not able to complete their tasks. 38503 IV. Resident #8 A. Resident status Resident #8, age less than 60, was admitted on [DATE]. According to April 2021 CPO, diagnoses included polyneuropathy, asthma, diabetes mellitus, difficulty walking, muscle weakness, depressive episodes, acute embolism and thrombosis. The 1/4/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required limited one-person assistance with most activities of daily living (ADLs) and one-person physical help in part of bathing activity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations and resident interview On 4/13/21 at 9:11 a.m., Resident #8 was observed propelling himself in his wheelchair down to the smoking area. Resident #8 was interviewed on 4/21/21 at 9:10 a.m. He said no one had taken him for a walk and he had not received his restorative therapy in over a month. At this time the resident was observed propelling himself in his wheelchair down to the smoking area. C. Record review The Restorative Plan Competency and Discharge Planning Form dated 2/10/21 revealed a physical therapist (PT) recommended Resident #8 walk with a four wheeled walker from room to/from the smoking area with one to two rest breaks as needed (the resident required stand by assist) and Resident #8 was to perform standing leg exercises (marches, heel/toe raises, partial squats 15 times, two to three sets with the walker). The care plan initiated on 4/8/21 revealed Resident #8 was on a walking program, the care plan did not include the resident was to perform standing leg exercises. Review of the April 2021 CPO revealed no order for restorative therapy. Review of Resident #8's Kardex for February 2021 revealed no documentation of the restorative program. Review of Resident #8's Kardex for March 2021 revealed no documentation of the restorative program. Review of Resident #8's Kardex for April 2021 revealed Resident #8 was on a walking program PRN (as needed). Additionally there was no documentation that the task had been performed. D. Staff interviews (Cross reference F725) Restorative aide (RA) #4 was interviewed on 4/14/21 at 12:44 p.m. She said she had been pulled to the floor frequently for the last three months (including today) and did not complete the residents' restorative programs. RA #3 was interviewed on 4/19/21 at 11:30 a.m. He stated that he was one of the restorative nurse aides that worked on the Eldorado unit. He worked at least two days per week on the floor as a CNA, if not more often. When he worked on the floor that often, he was not able to provide the restorative therapy the resident's needed. RA #7 was interviewed on 4/19/21 at 1:30 p.m. She stated that she worked four shifts a week and was a restorative aide. She worked as a certified nurse aid (CNA) on the floor three to four times a week in place of providing the restorative care program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing home administrator (NHA), director of nursing (DON), assistant director of nursing (ADON) and the rehabilitation director were interviewed on 4/20/21 at 1:50 p.m. The rehabilitation director said there were seventy seven residents who were on a restorative nursing program. She said therapy would create the residents functional program and the restorative aides would complete the residents programs as orders and document it under tasks in the electronic record. The NHA and DON said they felt they were providing the restorative program as adequately as they could. The NHA said all managers took a weekly rotation with scheduling staff and they tried to ensure that the restorative aides were not pulled frequently to the floor so that they could complete resident restorative programs (Cross-reference F725 the facility failed to consistently provide adequate nursing staff which considered the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents). The ADON said the CNA staff on the floor would complete range of motion with ADL care. However, the facility acknowledged the range of motion performed was not specific to each individual's restorative functional program as a resident's program could be active or passive, could include the use of splints or weights and could include multiple repetitions. V. Follow-up The Continuous Quality Improvement Plan dated 3/28/21, (target date of completion of 4/30/21) was provided by the NHA on 4/22/21 at 9:15 a.m. Approaches included to complete restorative program training, review current plans to ensure they were meeting the needs of the residents, review current resident's with splints, provide restorative training to CNAs, provide restorative training opportunities to nursing management staff, weekly meetings to review the restorative caseload, complete audits of restorative caseload, care plans, orders, and residents with splints. Although the quality improvement plan was in place it did not address how they would provide sufficient staffing to perform the restorative nursing program for the residents. Record review and interviews, a restorative nursing program was in place for residents; however, it had not been implemented due to insufficient nursing staff (see above in record review and interviews).

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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** 40221 Based on interviews and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for one (#161) of three residents reviewed for falls out of 68 sample residents. The facility failed to ensure for Resident #161 who had Alzheimer's disease and staff were to anticipate his needs was provided with frequent checks to prevent multiple falls. The facility failed to have a care plan in place to prevent Resident #161 from sustaining multiple falls (cross reference F656). Resident #161 had increased pain (cross reference F697) after his first fall and continued to have difficulty with increased pain and the lack of supervision from staff. Furthermore, the facility failed to order an x-ray for Resident #161 who could not express his needs but pointed and rubbed his left knee. This caused a delay in treatment for Resident #161, including pain management, cross reference F697, who sustained major injuries. These failures led to Resident #161 needing hospital treatment and surgery. Resident #161 presented to the emergency room with slight shortening of the left lower extremity with limited range of motion of the left hip due to pain and was in moderate distress. The findings from the computerized tomography (CT) scan were: Acute lumbar (L) 4 and L5 vertebral body superior endplate fractures with associated height loss that is mild to moderate involving the L5 vertebral body, and acute left femoral neck fracture with angulation and impaction. Findings include: I. Facility policy and procedure The Fall Prevention Program policy and procedure, dated 10/8/2020, provided by the nursing home administrator (NHA) on 4/20/21 at 8:30 a.m. read in pertinent part: -All residents will be assessed for the risk for falls 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 minimize falls, avoid repeat falls and minimize falls resulting in significant injury. -Residents identified at being at risk will have interventions identified in their plan of care to minimize falls. -The resident's plan of care will be updated to reflect risk for falls, and appropriate interventions. -When a fall occurs, the following will be done: -The licensed nurse will complete a thorough assessment of the resident to evaluate for injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The licensed nurse will notify the physician and the family/responsible party. -Treatment will be initiated per physician orders. -An incident report will be completed. -The resident's plan of care will be updated to reflect interventions. II. Resident #161 A. Resident status Resident #161, age 79, was admitted [DATE] and readmitted [DATE] and discharged on [DATE]. According to the November 2020 computerized physician orders (CPO) diagnoses included Alzheimer's disease, closed fracture with routine healing, pain in left hip, acute pain due to trauma, aftercare following explantation (removal of tissue) of hip joint prosthesis, unspecified fracture of unspecified lumbar vertebrae. -The fractures were added to the orders from the falls sustained in the facility. The 11/27/2020 minimum data set (MDS) assessment revealed he was negative for mood and behavior symptoms. He required extensive assistance of two staff members for bed mobility, transfers, and was dependent on one staff member for toilet use and personal hygiene. He was not steady and only able to stabilize with staff assistance during transitions of moving from seated to standing and surface to surface transfers. He had impairment of one side of the lower extremity and used a wheelchair for mobility. He was positive for hip replacement for hip fracture and other fractures. No falls since readmission. He had a surgical incision to his left hip. He received scheduled and as needed (PRN) pain medications for facial expressions of pain three to four days of the last five days. He received four out of seven days of anticoagulant injections and two out of seven days of opioid pain medication. Refer to the 11/15/2020 MDS assessment in the progress notes. B. Record review The 9/9/2020 fall scale evaluation indicated the resident was a low risk for falls as he did not require ambulatory aids and his gait was steady. The 9/9/2020 pain evaluation indicated he had no verbal or non-verbal indicators of pain. The 9/9/2020 nursing admission screening indicated he was independent with transfers and walking but needed extensive assistance with toilet use. He was alert and oriented only to self. He did not have pain. The 9/9/2020 baseline admission care plan indicated he did not require assistance from staff with transfers or walking and he did not use any mobility devices. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan, initiated 9/10/2020 revealed Resident #161 had impaired cognitive function and or thought processes related to Alzheimer's disease. Interventions included to cue, reorient, and supervise as needed. Anticipate and meet needs. -There was no care plan for falls. The 9/11/2020 physician admission history and physical indicated Resident #161 was admitted from home with progressive dementia as he was in need of more assistance with activities of daily living (ADLs). He was to be comfort measures only status and followed by palliative care. The 11/14/2020 pain evaluation after two falls indicated he was having pain to his left knee and thigh. The 11/15/2020 discharge-return anticipated MDS revealed he was positive for behavior symptoms of physical and verbal behaviors directed towards others, wandering, and rejection of care. He was always incontinent of bowel and bladder. He received PRN non-narcotic pain medications. He was positive for two or more falls with major injury and received an opioid pain medication one out of seven days. The 11/23/2020 nursing readmission screening indicated he returned to the facility after a hospital stay for a closed displaced fracture of the left femoral neck and closed fractures of lumbar vertebral bodies. He was dependent on staff for ADLs. The 11/30/2020 physician progress note, following readmission from the hospital for left hip hemiarthroplasty, indicated the resident grimaced with movement and required narcotic pain medication for uncontrolled pain. III. Sequence of events Fall #1 The nursing note on 11/13/2020 at 8:00 a.m., documented by licensed practical nurse (LPN) #10 read: This nurse called to resident's room by certified nurse aid. Resident found on floor, lying on his left side next to bed. Registered nurse/wound nurse called in and assessed resident. Resident able to move all extremities without difficulty. Small abrasion noted to left side of upper lip, with small amount of blood and area cleansed and no further drainage. Small abrasion noted to left elbow and cleansed and non draining. No other bruising found. This fall was unwitnessed. Resident assisted by 2 staff to stand and to lay in bed. Brief changed for small amount of urine. Assisted resident to bathroom and no further output. Assisted resident to lay in bed and bed in low position, Call light placed in resident's hand and reminded to call if wants to get up. Will make frequent room checks for needs per staff D/T (due to) resident's forgetfulness. (vital signs)VS=97. 9-71-16-128/60-95%RA (room air). Neuros (neurological assessment WNL (within normal limits). PERL (pupils equal and reactive to light). Director of nursing (DON) informed, son called and left message on voice mail, physician and clinic/service called and gave information. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing note on 11/13/2020 at 8:04 a.m., documented by the wound registered nurse (WRN) read: Called to room - Resident found lying on back on floor beside bed. Small abrasion to Upper L (left) lip noted with drying blood . Small bruising with abrasion to L elbow measure 2.5x2 no bleeding. No rotation noted to hips or legs. Able to have full mobility to upper and lower ext. no pain to palpation. Assisted up to bed. Noted brief was wet. Resident with no verbal response when asked if was heading to bathroom. Resident assisted to bathroom and dry brief placed. Neuro checks initiated. According to the investigation after this fall, frequent checks were to be initiated. The director of nursing (DON) did not provide documentation that frequent checks were initiated or completed. Interdisciplinary team (IDT) note dated 11/16/2020 read in part: Resident denies pain and discomfort. Vital signs every shift for 72 hours. Neuros per facility protocol, treatments as ordered, observe for signs and symptoms of infection, therapy screen, observe for increased pain, injury and bruising, nurse education regarding treatment orders, offer frequent toileting. Fall #2 The incident note on 11/14/2020 at 12:15 p.m., documented by LPN #10 read: CNA called this nurse to 1100 hall and resident found sitting up and leaning against wall in hallway, this fall was unwitnessed. RN called to hall and assessed resident. Resident able to move extremities x4, no visible bruising. Assisted by 3 staff to stand resident and to sit him in chair and then taken to room and assisted to sit on side of bed. VS=98. 4-82-16-110/61-pulse ox=93% RA. Resident unable to verbally communicate D/T dementia. Resident is pointing and rubbing left knee. Resident assisted by 3 staff to stand and then sit in chair and then transferred to his bed and sitting on bedside. VS and neuros initiated. PERL. Resident brief changed for small amount of urine. Call light place in hand and instructed to use to call before getting up from bed. Resident is not able to state understanding. Bed in low position. Frequent room checks initiated. DON called and left message, nursing supervisor aware, Son called and left message on voice mail, physician called and informed. -The resident with Alzheimer's disease was pointing and rubbing left knee. No x-ray was ordered to rule out major injuries. The incident note on 11/14/2020 at 12:31p.m., documented by registered nurse (RN) #3 read: RN called to Golden Gate for assessment. Arriving in 1100 hall way this resident was sitting on the floor against the wall across his room. Resident assessed head-to-toe. Pupils are PERLLA. Resident has severe dementia. He couldn't answer any questions per base line. No nausea and/or vomiting noted. Resident has fall yesterday per nurse verbal report. Vital signs are: 110/61, 82, 16, 98.4 and the pulse Oxymeter (sic) unable to read Oxygen saturation. I asked the nurse to use different Pulse Oxymeter and call DON for any abnormality. Resident normally able to walk without assist device, but this time he is not able to stand straight. Resident assisted to chair and pushed to his room by his nurse. His nurse and me assisted resident to his bed. Resident is moaning while assisted to stand and he is holding his left knee. I told the nurse to call DON and explain the situation and see if she wanted us to perform X-ray on his both knee, ankles and hips just to rule out any dislocation and/or fracture. Cross-reference F697. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT note dated 11/16/2020 read: Vital signs every shift for 72 hours, neuros per facility protocol, therapy screen, observe for increased pain, injury and bruising, pain medication order received, nurse education on completing UDAs/incident report, investigate bright colored tape on call light as a reminder to call for assistance. The therapy screening was not completed until 11/25/2020, after the resident returned from the hospital on 11/23/2020 and indicated he required assistance with ADls, related to decreased safety awareness, reduced upper/lower extremity functioning or muscle weakness, alterations in mobility, poor positioning/body alignment, pain, and history of falls. Fall #3 The incident note on 11/14/2020 at 2:44 p.m., documented by RN#3 read: RN called to Golden Gate for assessment. Arriving in 1100 hallway this resident was lying on the floor on his right side next to his bed, his head is towards the drawer by the curtain. Resident assessed head-to-toe. Pupils are PERLLA. Resident has severe dementia. He couldn't answer any questions per base line. No nausea and/or vomiting noted. Resident has fall yesterday per nurse verbal report. This is his second incident today. Vital signs are WNL per base line. I asked the nurse to call DON and notify the incident. Resident normally able to walk without assist device. The weekend supervisor notified the incident and she start called the DON. Resident is moaning while he is holding his left knee. I told the nurse to call DON and explain the situation and see if she wanted us to perform X-ray on his both knee, ankles and hips just to rule out any dislocation and/or fracture. I left resident to the nurse who is assigned to provide direct care and the weekend supervisor. They said they will take care of the neruro check and notifying provider and family. The late entry nurses note on 11/14/2020 at 3:45 p.m., documented by LPN #6 read: Called to Golden Gate to find resident on floor laying on right side clutching left leg bent at knee and moaning loudly in pain. Resident unable to straighten left leg during RN assessment. Resident lifted to bed and lowered to lowest position and fall mats placed on floor. No bruising noted at this time. Call placed to on-call MD advised of pain and pt unable to straighten leg. No x-rays ordered at this time. Shortly after, RN from Palliative called and order received for x ray to left hip, Left knee, left femur. RN advised she would notify the on-call MD (medical doctor) of verbal order. Call placed to pt (patient) son no answer detailed message left. LPN #6 documented a late entry note related to fall #3 on 11/15/2020 at 1:32 p.m., it read: Called to Golden Gate for reported fall of resident 2nd one this shift. Upon arrival resident noted to be on floor by bed laying on right side holding left leg bent at knee. Resident moaning very loudly with RN assessment. Call placed to on-call MD to request x rays. Denied. Call then from RN palliative care and order received. Charge nurse advised of order. Resident lifted placed in bed. Bed placed in low position with fall mat on floor by bed. Call light within reach. Call placed to resident son x 5 detailed message left. Staff advised to monitor pain. Injury reported to DON. Fall #4 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurses note on 11/14/2020 at 4:21p.m., documented by LPN #7 read: This nurse heard bang and resident screaming in room [ROOM NUMBER], went to see and found this resident laying on the floor on his right lateral side of the body holding left knee and the head against the bedside commode, appeared to be in pain 8/10, RN came in and assessed resident with no swelling, noted resident continually holding left knee during the whole times, resident unable to describe what happened and how happened due to dementia. 10 minutes prior the fall this nurse saw resident sitting on the bed. After RN assessed resident Physician was called and order was received to start Tramadol 50mg every 6 hrs PRN and also Diclofenac 1% 4 gram gel to apply to left knee 4 times per day. Resident was transferred back to bed, PRN Tylenol was given, bed in low position and bedside floor mat in place. will monitor resident as per facility protocol. Stat X Ray for left knee, left hip and left femur ordered received from the palliative nurse and later this order was discontinued. POA was notified via voice mail also DON. The nurses note on 11/14/2020 at 7:24 p.m., documented by LPN #7 read: Resident assessed by this nurse after one hr of Tylenol administration, pain subsided while resident is in bed but noted resident having severe pain when staff tried to positioned him and also during care, continue holding left thigh area. Nurse called physician and order received to have stat X Ray of the lumbar-sacral area, also left knee and left hip. Nurse unable to get Tramadol delivered at this time, spoke to Pharmacy staff and was told that stat delivery will take up to 4 hrs, requested to get from Pyxis (medication dispensing machine) and was told that machine not disponible. IDT note dated 11/16/2020 read: Stat x-ray for left knee, left hip and left femur ordered received from the palliative nurse and later this order was discontinued. Vital signs every shift for 72 hours, neuros per facility protocol, observe for increased pain, injury and bruising, bed placed in low position, floor mat placed next to bed. PRN Tramadol started and Diclofenac 1% 4 gram gel. Doctor called related to continued pain, x-ray ordered and resident had noted fracture, resident sent to ER for eval and treat. The nurses note on 11/15/2020 at 4:32 a.m. read: Resident remains on monitoring for fall, resident guards L (left) leg and yells out when leg is touched, pain medication (Tramadol) Administered per order. Awaiting X-ray. Will continue to monitor. The nurses note on 11/15/2020 at 7:30 a.m., documented by LPN #10 read: X-ray company in and taking ordered x-rays. The facility failed to notify the medical director of the inability to obtain an x-ray order resulting in a delay of seven hours after the resident fell three times with apparent injury. The x-ray was not completed until 19 hours after the first fall on 11/14/2020 at 12:15 p.m. with apparent injury and the resident was not sent to the hospital for 26 hours after initial injury. The x-ray report indicated an acute left hip fracture involving the femoral neck with displacement. The nurses note on 11/15/2020 at 2:40 p.m., documented by LPN #6 read: Results of x-ray called to on-call MD. Order received to send pt to the hospital for eval and tx Acute left hip fx. Call placed to the hospital report given to PA. Son called left detailed voicemail. DON notified. Ambulance called waiting arrival. A. Hospital records (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident presented to the emergency department at 4:19 p.m. on 11/15/2020 with the chief complaint of a left hip fracture. Upon examination there was slight shortening of the left lower extremity with limited range of motion of the left hip due to pain. He appeared to be in moderate distress, he was moving and waving his arms. After entry to the emergency department he received a dose of Fentanyl 50 micrograms (mcg) for his severe pain. Per the resident's son he was normally ambulatory without assistance. A computed tomography (CT) scan was performed and indicated: -Acute lumbar (L) 4 and L5 vertebral body superior endplate fractures with associated height loss that is mild to moderate involving the L5 vertebral body. -Acute left femoral neck fracture with angulation and impaction. He was scheduled for surgery the next day for repair of the hip fracture. He was discharged back to the facility on [DATE]. IV. Staff interviews LPN #6 was interviewed on 4/19/21at 9:18 a.m. She said on 11/14/2020 at 3:45 p.m. after the resident sustained his third fall of the day, she felt the resident was injured because he was in a lot of pain and he was moaning loudly. She said she notified the physician on-call of his pain and inability to straighten his left leg but he did not order x-rays or pain medication. He was on palliative care so she called that RN and received an order for x-rays. She said she only worked weekends and left shortly after she documented the incident and another nurse took over. She did not offer an explanation as to why the MD was not notified to obtain a pain medication order. LPN #10 was interviewed on 4/19/21 at 12:35 p.m. She said when the resident fell on [DATE] at 12:15 p.m. even though he was pointing to and rubbing his left knee, she did not think anything of it because he would point at different areas at different times. She said she did not consider him injured at that time. She said she had heard that after she left for the day he fell again and when the physician was notified he still would not order any x-rays or pain medication. She said she did not understand why the physician would do that. The minimum data set (MDS) coordinator was interviewed on 4/19/21 at 2:16 p.m. She said she would enter a fall care plan if she happened to catch one that was missing. She said there was a team of staff that were responsible for putting in fall care plans and it was not normally her job. RN #3 was interviewed on 4/19/21 at 4:53 p.m. He said he was called to the 1100 hall to assess the Resident #161 when he fell at 12:15 p.m. on 11/14/2020. He said the resident was normally up walking around but when he fell and they tried to assist him to stand he was moaning loudly and holding his left knee. He said it was clear the resident was in quite a bit of pain and he was afraid he may have dislocated or fractured his hip. He said once he did his assessment and told the resident's nurse to notify the physician and the DON, he went back to his hall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON and unit manager (UM) #1 were interviewed on 4/20/21at 9:11 a.m. UM #1 said at the time of Resident #161's falls on 11/14/2020 he was in training for unit manager. The DON was not completely certain that she was notified of the resident's falls each time. She said the expectation was for the nurses to notify the physician to get an order for an x-ray and an order to be sent to the hospital for evaluation especially since the resident was in pain. She said according to the nursing documentation of the fall events it was obvious the resident had suffered an injury and needed treatment. She said even if residents were on hospice or palliative care, the nursing staff was required to seek treatment for any apparent injury and the facility would pay for x-rays if they were not covered. She said she would call the physician to see why the palliative nurse's x-ray order was discontinued, and why there was no pain medication ordered when advised of the fall, his pain, and inability to straighten his leg at 3:45 p.m. on 11/14/2020. She said she would call the pharmacy to see why, on 11/14/2020 at 7:24 p.m., the nurse was told the Tramadol could not be obtained from the medication dispensing machine (Pyxis). LPN #7 was interviewed on 4/20/21 at 3:13 p.m. He said when Resident #161 fell at 4:21 p.m. on 11/14/2020 he felt he had suffered a fracture because he was screaming in pain and holding his left knee. LPN #7 called the physician on-call and received an order for the Tramadol and Voltaren Gel but he refused to order an x-ray because he said he did not have any swelling to the leg. The physician told the nurse to cancel the x-ray order that the palliative nurse had given him. LPN #7 said he became so frustrated with the physician because he was not listening to him. He said he spoke to the physician again three hours later when the resident was having severe pain when the staff tried to position him during care and the physician finally agreed to do x-rays. LPN #7 said he was told by the pharmacy that the Tramadol order would take at least four hours to get to the facility. LPN #7 called the pharmacy again to get authorization to obtain the medication out of the Pyxis and was told the machine was not working correctly and the medication could not be dispensed from it, even though the medication was in the machine. He said he did not think to ask the physician for an alternate pain medication because the physician already knew the situation and the physician did not offer to order the resident anything else. He did not think to notify the MD of the situation to obtain an x-ray order or have the MD call the pharmacy to obtain authorization to remove the pain medication from the Pyxis. The DON was again interviewed on 4/21/21 at 8:21 a.m. She said the pharmacy director told her when the order for Tramadol came to them it was put in as a STAT order and when the nurse called the pharmacy to be able to get a dose out of the Pyxis he was told he could not pull it from the machine because the medication was already with the courier on its way to the facility and the amount prescribed was in that order. They could not pull more from the machine because it would be over the tablet amount ordered by the physician. The DON said she was unaware of this particular procedure with the pharmacy. She acknowledged it was a problem that needed to be fixed because of the delay with the resident receiving the ordered pain medication timely. She said she will start a new procedure that will require the nurses to tell the pharmacy they will obtain the first dose of a pain medication from the Pyxis so the resident would not have to wait until the pharmacy delivered the medication, possibly several hours later. The DON was interviewed on 4/21/21 at 8:17 a.m. She said she spoke with Resident #161's physician and she said when the multiple falls occurred on 11/14/2020 a male on-call physician (name unknown) was the one the facility nurse spoke to that had cancelled the x-ray orders from the palliative RN and would not order pain medication. She could not offer an explanation for his actions. She agreed that should not have happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility medical director (FMD) was interviewed on 4/21/21 at 10:17 a.m. He said he was unaware of the circumstances surrounding Resident #161 and in his opinion he felt the facility responded correctly and the resident was treated in a timely manner following the multiple falls. He did not offer any information as to what the facility could have done differently for the resident, although he would have been available to them for consultation. Physician #1 was interviewed on 4/21/21 3:40 p.m. She said she reviewed the communication of the phone calls from the nurses to the on-call physician after each fall the resident had on 11/14/21. She said when the resident had the first fall at 12:15 p.m. and could not stand and was having pain, rubbing his left knee and pointing to it, the physician should have ordered an x-ray and pain medication at that time. Having not intervened timely resulted in the resident having extreme pain and not being sent to the hospital for treatment for 26 hours after the original injury. The DON was interviewed on 4/21/21 at 4:02 p.m. She said when Resident #161 had the multiple falls on 11/14/2020 and the nurses were having difficulty obtaining orders from the on-call physician for an x-ray and pain medication, they should have called the FMD for orders. She said, I'm not sure they would have known to do that, but she would educate them on the need to notify the FMD if they were having difficulty with a physician and they were not ordering what they felt was necessary according to their assessment. V. Facility follow up On 4/22/21 at 11:00 a.m. the DON provided a copy of a sign that will be posted at each nursing station that read: In the event your resident is in need of immediate care your first step is to call the attending physician. If attending does not answer/return call or doesn't agree with your nursing assessment your medical director is available for a second opinion and additional support. The FMD's name and phone number was listed as well.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40221 Based on interviews and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one (#161) of four residents reviewed for pain management out of 68 sample residents. The facility failed to ensure sufficient pain medication orders were obtained timely after Resident #161 (who had Alzheimer's disease, and staff were to anticipate his needs) had multiple falls (three in a four hour period on 11/14/2020, see record review below) resulting in major injury (cross-reference F689 for falls) and increased pain. In addition, the facility failed to ensure pain medication was available to be administered timely which resulted in the resident having unrelieved pain for over 13 hours of his first documented signs and symptoms of pain (see record review below). Findings include: I. Facility policies and procedures The Pain Management Program Policy, dated 10/8/2020, revised August 2020, provided by the staff development coordinator (SDC) on 4/19/21 at 11:16 a.m. read in pertinent part: -The facility and interdisciplinary team (IDT) will identify individuals who have pain or who are at risk for having pain. -The facility will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. -IDT will make attempts to determine root cause of pain and collaborate with physician to conduct necessary diagnostics and evaluation to identify potential source of pain and determine plan of care. -Create pain care plan-pain in advanced dementia for those residents with a dementia type diagnosis, those non-verbal residents, comatose residents and those not able to verbalize pain. -Obtain orders for pharmaceutical interventions, pain medications,and or non-pharmaceutical interventions. -The nurse will assess the resident every shift for pain on the medication administration record (MAR). -If a resident is assessed as experiencing pain during that shift, then pain medication and or alternative therapies should be administered as ordered. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-For pain that is not managed through the current care plan the resident should be assessed for new causes of the pain and or the need for a change in frequency, dose or a new intervention. -With a new onset of pain, complete a pain evaluation. Determine an appropriate pharmacological intervention under the direction of the physician. The Medication Ordering and Receiving Controlled Medications From Pharmacy Provider policy dated 2007, revised January 2020, provided by the NHA on 4/20/21 at 4:40 p.m. read in pertinent part: -In an emergency situation, verbal authorization may be given by the prescriber to the pharmacist for a new order as described by law. The Pharmacy Medication Ordering instruction sheet, dated 9/17/19, provided by the assistant nursing home administrator (ANHA) on 4/20/21 at 4:54 p.m. read in pertinent part: -For new orders please send the original physician's order as soon as it is written. First doses may be available from the emergency kit, but require a call to the pharmacy for controlled substances. -Please call and fax any emergency or immediate (STAT) order requests directly to the pharmacy. -Please call the pharmacy for any emergency requests outside of scheduled deliveries. II. Resident #161 A. Resident status Resident #161, age 79, was admitted [DATE] and readmitted [DATE]. The resident discharged on [DATE]. According to the November 2020 computerized physician orders (CPO) diagnoses included closed fracture with routine healing, pain in left hip, acute pain due to trauma, aftercare following explantation (removal of tissue) of hip joint prosthesis, unspecified fracture of unspecified lumbar vertebrae and Alzheimer's disease. -The pain in the left hip was added after the resident had fallen and sustained a left hip fracture (see below). The 11/27/2020 minimum data set (MDS) assessment indicated Resident #161 was rarely/never understood with a brief interview for mental status (BIMS) score of zero out of 15. He was negative for mood and behavior symptoms. He required extensive assistance of two staff members for bed mobility, transfers, and was dependent on one staff member for toilet use and personal hygiene. He had impairment of one side of the lower extremity and used a wheelchair for mobility. He was positive for hip replacement for hip fracture and other fractures. He received scheduled and PRN pain medications for facial expressions of pain three to four days of the last five days. He had a surgical incision to his left hip. He received four out of seven days of anticoagulant injections and two out of seven days of opioid pain medication. Refer to the 11/15/2020 discharge MDS in the record review. B. Record review (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The 9/9/2020 pain evaluation upon admission indicated he had no verbal or non-verbal indicators of pain and the pain evaluation completed on 11/14/2020 after two falls indicated he was having pain to his left knee and thigh. The 9/9/2020 nursing admission screening indicated he was independent with transfers and walking but needed extensive assistance with toilet use. He was alert and oriented only to self. He did not have pain. The 9/9/2020 MDS assessment revealed Resident #161 was not receiving a scheduled pain medication regimen. He did not receive PRN pain medications and did not receive non-medication intervention. The care plan, initiated 9/10/2020 revealed Resident #161 had impaired cognitive function and or thought processes related to Alzheimer's disease. Interventions included to cue, reorient, and supervise as needed. Anticipate and meet needs. -There was no care plan for pain. The 11/15/2020 discharge-return anticipated MDS revealed he was positive for behavior symptoms of physical and verbal behaviors directed towards others, wandering, and rejection of care. He received as needed (PRN) pain medication. He was positive for two or more falls with major injury and received opioid pain medication one out of seven days. The 11/23/2020 nursing readmission screening indicated he returned to the facility after a hospital stay for a closed displaced fracture of the left femoral neck and closed fractures of lumbar vertebral bodies. He was dependent on staff for ADLs. The 11/30/2020 physician progress note, following readmission from the hospital for left hip hemiarthroplasty, indicated the resident grimaced with movement and required narcotic pain medication for uncontrolled pain. C. Sequence of events (Cross-reference F689 failure to ensure resident safety and obtain x-ray timely after repeated falls with increased pain) Fall #1 Resident #161 had a fall on 11/13/2020 at 8:00 a.m. in his room and received abrasions but did not indicate he had pain. The IDT note dated 11/16/2020 read in part: Resident denies pain and discomfort. Vital signs every shift for 72 hours. Neurological checks per facility protocol, treatments as ordered, observe for signs and symptoms of infection, therapy screen, observe for increased pain, injury and bruising, nurse education regarding treatment orders, offer frequent toileting. Fall #2 The resident sustained a fall on 11/14/2020 at 12:15 p.m. in the hallway. At that time he was unable to stand straight and was moaning and holding his left knee. -There was no documentation on the MAR of the resident receiving any pain medication at this time after he moaned and was holding his left knee. No pain medication order was obtained after this fall. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Fall #3 The resident fell again on 11/14/2020 at 2:44 p.m. in his room. He again was clutching his left leg bent at the knee and moaning very loudly in pain. He was unable to straighten his left leg. A call was placed to the on-call physician and he was advised of the pain and the resident's inability to straighten his left leg. -No x-rays or pain medication were ordered at this time. The nursing staff failed to contact the facility medical director (FMD) to notify him of the situation and the need for x-ray and pain medication orders. Fall #4 The resident had another fall on 11/14/2020 at 4:21p.m. in his room. He was found holding his left knee and appeared to be in severe pain rated at an eight out of ten. Only at this time, after the physician was notified of yet another fall, was a narcotic pain medication (Tramadol) ordered. The nurses note dated 11/14/2020 at 7:24 p.m. revealed licensed practical nurse (LPN) #7 went to check on the resident and he was having severe pain and was holding his left thigh area. The Tramadol order that was received three hours earlier still had not arrived from the pharmacy. LPN #7 was unable to get the Tramadol delivered. He spoke to pharmacy staff and was told that an immediate (STAT) delivery would take up to four hours. The LPN requested to get the medication from the medication dispensing machine (Pyxis) and was told that the machine would not dispense it even though the medication was in the machine. -The facility failed to contact the FMD to notify him of the situation resulting in delayed administration of the pain medication. The order administration note on 11/15/2020 at 1:21 a.m. revealed the resident did not receive the first dose of Tramadol until nine hours after the order was received and 13 hours after the first fall with injury on 11/14/2020 at 12:15 p.m. The Tramadol was given again at 7:05 a.m. and 1:23 p.m. on 11/15/2020. He was transferred to the hospital on the afternoon of 11/15/2020. D. Emergency department note The resident presented to the emergency department at 4:19 p.m. on 11/15/2020 with the chief complaint of a left hip fracture. Upon examination there was slight shortening of the left lower extremity with limited range of motion of the left hip due to pain. He appeared to be in moderate distress, he was moving and waving his arms. After entry to the emergency department he received a dose of Fentanyl 50 micrograms (mcg) for his severe pain. III. Staff interviews (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	LPN #6 was interviewed on 4/19/21at 9:18 a.m. She said on 11/14/2020 at 3:45 p.m. after the resident sustained his third fall of the day, she felt the resident was injured because he was in a lot of pain and he was moaning loudly. She said she notified the physician on call of his pain and inability to straighten his left leg but he did not order x-rays or pain medication. He was on palliative care so she called the palliative registered nurse (RN) and received an order for x-rays. She said she only worked weekends and left shortly after she documented the incident and another nurse took over. LPN #10 was interviewed on 4/19/21 at 12:35 p.m. She said when the resident fell on [DATE] at 12:15 p.m. even though he was pointing to and rubbing his left knee, she did not think anything of it because he would point at different areas at different times. She said she did not consider him injured at that time. She said she had heard that after she left for the day the resident fell again and when the physician was notified he still did not order any x-rays or pain medication. She said she did not understand why the physician would do that. RN #3 was interviewed on 4/19/21 at 4:53 p.m. He said he was called to the 1100 hall to assess Resident #161 when he fell at 12:15 p.m. on 11/14/2020. He said the resident was normally up walking around, but when he fell the staff tried to assist him to stand he was moaning loudly and holding his left knee. He said it was clear the resident was in quite a bit of pain and he was afraid he may have dislocated or fractured his hip. He said once he completed his assessment (of the resident) and told the resident's nurse to notify the physician and the DON, he went back to his hall. The DON and unit manager (UM) #1 were interviewed on 4/20/21 at 9:11 a.m. UM #1 said at the time of Resident #161's falls on 11/14/2020 he was in training for unit manager. The DON said she was not completely certain that she was notified of the resident's falls each time. She said the expectation was for the nurses to notify the physician to get an order for an x-ray and an order to be sent to the hospital for evaluation especially since the resident was in pain. She said according to the nursing documentation of the fall events it was obvious the resident had suffered an injury and needed treatment. -She said even if residents were on hospice or palliative care, the nursing staff were required to seek treatment for any apparent injury and the facility would pay for x-rays if they were not covered. She said she would call the physician to see why there was no pain medication ordered when advised of the fall, his pain, and inability to straighten his leg at 3:45 p.m. on 11/14/2020. She said she would call the pharmacy to see why, on 11/14/2020 at 7:24 p.m., the nurse was told the Tramadol could not be obtained from the medication dispensing machine (Pyxis). LPN #7 was interviewed on 4/20/21 at 3:13 p.m. He said when Resident #161 fell at 4:21 p.m. on 11/14/2020 he felt he had suffered a fracture because he was screaming in pain and holding his left knee. LPN #7 called the physician on call and received an order for the Tramadol and Voltaren Gel. LPN #7 said he was told by the pharmacy that the Tramadol order would take at least four hours to get to the facility. LPN #7 called the pharmacy again to get authorization to obtain the medication out of the Pyxis and was told the machine was not working correctly and the medication could not be dispensed from it, even though the medication was in the machine. He said he did not think to ask the physician for an alternate pain medication because the physician already knew the situation and the physician did not offer to order the resident anything else. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The DON was again interviewed on 4/21/21 at 8:21 a.m. She said the pharmacy director told her when the order for Tramadol came to them it was put in as a STAT order and when the nurse called the pharmacy to be able to get a dose out of the Pyxis he was told he could not pull it from the machine because the medication was already with the courier on its way to the facility and the amount prescribed was in that order. They could not pull more from the machine because it would be over the tablet amount ordered by the physician. The DON said she was unaware of this particular procedure with the pharmacy. She acknowledged it was a problem that needed to be fixed because of the delay with the resident receiving the ordered pain medication timely. She said she will start a new procedure that will require the nurses to tell the pharmacy they will obtain the first dose of a pain medication from the Pyxis so the resident would not have to wait until the pharmacy delivered the medication, possibly several hours later. The DON was interviewed on 4/21/21 at 8:17 a.m. She said spoke with Resident #161's physician and she said when the multiple falls occurred on 11/14/2020 a male on-call physician (name unknown) was the one the facility nurse spoke to that had cancelled the x-ray orders from the palliative RN and would not order pain medication. She could not offer an explanation for his actions. She agreed that should not have happened. The facility medical director (FMD) was interviewed on 4/21/21 at 10:17 a.m. He said he was unaware of the circumstances surrounding Resident #161 and in his opinion he felt the facility responded correctly and the resident was treated in a timely manner following the multiple falls. He did not offer any information as to what the facility could have done differently for the resident, although he would have been available to them for consultation. Physician #1 was interviewed on 4/21/21 3:40 p.m. She said she reviewed the communication of the phone calls from the nurses to the on-call physician after each fall the resident had on 11/14/21. She said when the resident had the first fall at 12:15 p.m. and could not stand and was having pain, rubbing his left knee and pointing to it, the physician should have ordered an x-ray and pain medication at that time. Having not intervened timely resulted in the resident having extreme pain and not being sent to the hospital for treatment for 26 hours after the original injury. The DON was interviewed on 4/21/21 at 4:02 p.m. She said when Resident #161 had the multiple falls on 11/14/2020 and the nurses were having difficulty obtaining orders from the on-call physician for an x-ray and pain medication, they should have called the FMD for orders. She said, I'm not sure they would have known to do that, but she would educate them on the need to notify the FMD if they were having difficulty with a physician and they were not ordering what they felt was necessary according to their assessment. IV. Facility follow up On 4/22/21 at 11:00 a.m. the DON provided a copy of a sign that would be posted at each nursing station that read: In the event your resident is in need of immediate care your first step is to call the attending physician. If attending does not answer/return call or doesn't agree with your nursing assessment your medical director is available for a second opinion and additional support. The FMD's name and phone number was listed as well.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38503 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide adequate nursing staff which considered the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents. As a result of inadequate staffing, the facility failed to provide services and treatment to prevent multiple areas of concern: F561 failure to provide showers as requested; F677 failure to provide assistance with activities of daily living; F684 Failure to monitor the resident for bleeding resulting in a harm level; F688 failure to provide a consistent restorative nursing program per therapy recommendation; and, Findings include: I. Facility policy The Emergency Staffing Strategy policy, undated, was provided by the nursing home administrator (NHA) on 4/19/21 at 11:30 a.m. It documented in pertinent part, In the event that an emergency significantly effects (sic) the ability of our workforce to function in its normal capacity. The facility will employ the following interventions to ensure that we are able to care for our residents. -Staff will be cross trained to support interdepartmental functions, dietary, housekeeping and feeding. Contact contracted staffing agencies to provide additional support, solicit assistance from staff currently employed at other (name of facility) facilities and hire hospitality aides to assist with support services such as passing ice water, answering call lights, taking menu orders, delivering linens and supplies and providing 1:1 (one to one) care. II. Resident Census and Conditions The 4/13/21 Census and Conditions of residents report revealed the current census of 166 residents. The following required one to two-person assistance or was dependent for the following ADLs: -Bathing, 100 residents required one or two staff and 56 were dependent; -Dressing, 155 residents required one or two staff and 10 were dependent; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Transferring, 120 residents required one or two staff and 40 were dependent; -Toilet Use, 128 residents required one or two staff and 26 were dependent; -Eating, 106 residents required one or two staff and 12 were dependent; and, -27 residents had contractures and 22 admitted with a contracture. III. Residents who required two-person assistance, Hoyer lift or sit to stand transfers An alphabetical list of residents (census per each unit) was provided by the director of nursing (DON) on 4/14/21 was 162 residents. The Eldorado/Rapid recovery unit had 44 residents, Golden Gate unit had 67 residents and Summit Park unit had 51 residents. There were 15 residents who required two-person assistance, Hoyer lift or sit to stand transfers on the Eldorado/Rapid recovery unit (four on the 100 hall, two on the 200 hall, six on the 300 hall, one on the 400 hall and two on the 500 hall). There were 21 residents who required two-person assistance, Hoyer lift or sit to stand transfers on the Golden Gate unit (five on the 900 hall, four on the 1000 hall, five on 1100 hall and seven on the 1200 hall). There were 15 residents who required two-person assistance, Hoyer lift or sit to stand transfers on the Summit Park unit (seven on 2000 hall, four on the 2100 hall, zero on 2200 hall and four on the 2300 hall). IV. Staffing requirements for each station According to the desired staffing pattern documentation provided by the nursing home administrator (NHA) on 4/14/21 at 12:30 p.m., the nursing schedule was as follows: A. Day shift 6:00 a.m. to 2:00 p.m. and evening shift 2:00 p.m. to 10:00 p.m. Eldorado/Rapid recovery unit The unit required three to five licensed nurses and five to six CNAs for day and evening shift. The unit included 100 hall, 200 hall, 300 hall, 400 hall and 500 hallways. One certified nurse aide (CNA) was assigned to one on one (1:1). Meaning at times three nurses would split five hallways and four CNAs were to split five hallways. Golden Gate unit Day shift 6:00 a.m. to 2:00 p.m. and evening shift 2:00 p.m. to 10:00 p.m. The unit included 900 hall, 1000, 1100, and 1200 hallways. The unit required three licensed nurses and seven CNAs for day and evening shift (two CNAs for 900, 1100, 1200 and one CNA on 1000 hall). The nurse and a CNA from the 1100 hall were assigned to help on 1000 hall as there was only one CNA assigned to the hall. Summit Park unit (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Day shift 6:00 a.m. to 2:00 p.m. and evening shift 2:00 p.m. to 10:00 p.m. The unit included 2000 hall, 2100 hall, 2200 hall and 2300 hallways. The unit required three nurses and five CNAs. B. Night shift 10:00 p.m. to 6:00 a.m. Eldorado/Rapid recovery unit Night shift 10:00 p.m. to 6:00 a.m. The unit required two licensed nurses and five CNAs one of which was assigned 1:1. Golden Gate unit Night shift 10:00 p.m. to 6:00 a.m. The unit required two licensed nurses and three CNAs. Summit Park unit Night shift 10:00 p.m. to 6:00 a.m. The unit required two licensed nurses and three CNAs. However, the schedule above did not reflect the staff that actually worked the floor to assist residents. The staff did not match the schedule and the facility had less staff present (see record and interviews below). V. Working schedule Review of the facility working schedule from 3/18/21 to 4/18/21 revealed at times the working schedule did not have licensed nurses or CNAs scheduled according to resident needs and staff interviews. Review of the Eldorado/Rapid recovery unit revealed the staff worked with one less licensed nurse or one less CNA eight out of 31 days (blank or missing names on the schedule). Review of the Golden Gate unit revealed the staff worked with one less licensed nurse or one less CNA nine out of 31 days (blank or missing names on the schedule). Review of the Summit Park unit revealed the staff worked with one less licensed nurse or one less CNA six out of 31 days (blank or missing names on the schedule). Additionally, review of the working schedule revealed the restorative aides (RAs) were pulled to work the floor instead of providing restorative nursing according to the residents programs on the three units over 29 times. Cross-reference F688, failed to ensure consistent restorative services. VI. Resident interviews Cross-reference F561 failure to provide showers Resident #127 was interviewed on 4/12/21 at 2:20 p.m. He said staff were not providing his showers routinely. Resident #8 was interviewed on 4/12/21 2:54 p.m. He said he has not been receiving his showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #2 was interviewed on 4/12/21 at 3:08 p.m. He said he was not receiving his showers. Resident #8 was interviewed a second time on 4/21/21 at 9:10 a.m. He said he had not received his restorative therapy. He said it had been over a month since someone had taken him for a walk. Cross-reference F688 VII. Staff interviews CNA #12 was interviewed on 4/12/21 at 6:17 p.m. She said she worked at the facility since 2016 and worked 2:00 p.m. to 10:00 p.m. shift. She said there was supposed to be two CNAs on each hall. She said at the beginning of the shift that day there were only six CNAs on the schedule for the Golden gate unit which was not unusual, but someone was called to come help. She said the 1100 hall had eight residents who required two person assistance and or mechanical. She said when they were short she was not able to get her residents showered or pass ice water to residents. CNA #13 was interviewed on 4/13/21 at 4:53 p.m. She said she worked full time on the 2:00 p.m. to 10:00 p. m. shift. She said she also worked the weekends because the facility was short on the weekends. She said she could not complete all of her work such as showers or pass ice water and sometimes stayed late to complete her documentation. She said the residents who were less vocal were the residents who most likely would not receive their shower. Restorative aide (RA) #4 was interviewed on 4/14/21 at 12:44 p.m. She said she had been pulled to the floor frequently for the last three months (including today) and did not complete the residents' restorative programs. She said there was two RAs scheduled on each unit. She said there was no consistent scheduler so she often would be pulled to the floor and at times with only six CNAs scheduled on the Golden Gate unit instead of seven to eight CNAs. CNA #3 was interviewed on 4/14/21 at 12:51 p.m. She said just last week there were only six CNAs working day shift on the Golden gate unit (meaning two hallways only had one CNA assigned), so it was very hard to get all of their work done because the 900 hall had four residents who required Hoyer lift transfers. CNA #7 was interviewed on 4/15/21 at 1:32 p.m. She said she was from the agency staffing. She said the facility could use more staff. She said a lot of the residents had increased care needs. She said it was time consuming. She said more staff would help decrease the rushing. CNA #6 was interviewed on 4/15/21 at 2:01 p.m. She said the facility did not have enough staff. She said they had one CNA for 18 residents for the 1000 hall. She said she tried to get as much done as possible and then pass on to the next shift. Unit manager (UM) #1 was interviewed on 4/15/21 at 2:02 p.m. He said the facility was trying their best to ensure enough staffing. He said they were using agency staff and they offered bonuses. He said they were in the process of hiring 19 staff. He said the facility was struggling because of the COVID pandemic. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA #9 was interviewed on 4/17/21 at 10:15 p.m. She said she was agency staff and that the facility had tried to quit using agency staff but nobody wants to work here so they were calling them again. She said she was working a double shift, she had worked the day shift too. She said on the day shift a CNA had called in so she could not keep up to get all her work done and the nurse had to help her. CNA #2 was interviewed on 4/17/21 at 10:40 p.m. He said he worked 10:00 p.m. to 6:00 a.m. night shift for the last five years. He said most of the time on night shift there were only two CNAs when they needed three. He said he would ask the nurse for help but often were too busy. He said when they worked short he could not turn the residents or provide incontinent care every two hours during his shift like he was supposed to. He said the last time they worked with two CNAs was last week. RA #3 was interviewed on 4/19/21 at 11:30 a.m. He stated that he was one of the restorative nurse aides that worked on the Eldorado unit. He worked at least two days per week on the floor as a CNA, if not more often. When he worked on the floor that often, he was not able to provide the restorative therapy the resident ' s needed. RA #7 was interviewed on 4/19/21 at 1:30 p.m. She stated that she worked four shifts a week and was a restorative aide. She worked as a CNA on the floor three to four times a week in place of providing the restorative care program so this was not being done. LPN #2 was interviewed on 4/20/21 at 12:47 p.m. She said they did not have enough staff, mostly CNAs. She said she did as much as possible to provide care. CNA #20 was interviewed on 4/20/21 at 2:07 p.m. She said she was at the facility today because a staff member had called off. She said there was not enough staff. She said the nurses did not help much with care or call lights. She said she always had to stay late to get her work done. LPN #7 was interviewed on 4/20/21 at 3:13 p.m. He worked the 1100 hall and was supposed to have two CNAs on the evening shift and usually did not get them. He said his hall had several total assist residents that took up half the CNAs time on the shift. He said staff often did not get showers done because there is not enough help. He said at times there usually was just six CNAs instead of eight on the Golden gate unit. UM #1 and #3, Human resource (HR) and staff development coordinator (SDC) were interviewed on 4/20/21 at 11:01 a.m. They said for over a month no one was assigned to complete the schedule so all managers took turns weekly working on the schedule to ensure there was enough staff. They said the Golden Gate unit had 67 to 68 residents and usually had seven to eight CNAs and three nurses for the day and evening shift and three CNAs and two nurses for night shift. UM #1 said the staff that were assigned to the 1100 hallway were supposed to help the single CNA on the 1000 hallway. They said the Summit Park unit usually had five to six CNAs and three nurses for day and evening shift and two nurses and three CNAs for night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	UM #3 said the Eldorado/Rapid recovery unit census frequently fluctuated because of its admissions and discharges. He said today (4/20/21) the census was 41 and typically there would be five nurses and five CNAs on the unit for day and evening shift and two nurses and three to four CNAs at night. -He said there was one resident who required 1:1 care so a total of six CNAs were on El Dorado/Rapid recovery today. They acknowledged there were some care concerns surrounding not enough staffing. The NHA, DON and assistant director of nursing (ADON) were interviewed on 4/21/21 at 4:38 p.m. The NHA said recently they stopped using agencies as blocked booked (4 week or 8 week contracts) and now were utilizing them as needed. She said recently the facility hired a lot of new staff and management had been helping with the schedule to ensure the same restorative staff had not been pulled to the floor so often. -She said the facility considered putting some measures in place to stagger the restorative aides who had been pulled to the floor, so that maybe they were not on the floor the entire shift and could complete some of their restorative tasks. The NHA said the facility felt they were staffing appropriately because there were no grievances related to call lights. However, staffing is not solely based on call light times. Resident cares were not completed because of the facility failure to ensure enough staff were scheduled. Cross reference, F561, F677, F684, F688. VIII. Follow-up A quality assurance improvement plan dated November 2020 for Staffing was provided by the NHA on 4/22/21 at 9:15 a.m. documented under the area of concern read, recruiting and retention. Recruiting efforts included the following: Advertise, complete a wage analysis (October 2020); -Utilize applicant tracking system to source candidates and set up interviews (October 2020, March 2021/ongoing); -Corporate recruiter and corporate HR assigned to assist the facility with recruitment and hiring efforts (November 2020); -Word of mouth referral (March 2021); -Implement shift pick up bonuses (April 2021) and flew in additional nurses from sister facilities to help with floor coverage and support (present during the survey 4/12/21 to 4/22/21). -Implemented and recruited hospitality aides, added agency contracts, ongoing; -Added agency contracts x 3 (three) (no date of implementation or review); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Department heads support with hospitality functions such as call light response, passing meal trays, etc. (etcetera) (no date of implementation or review); -Reviewed applicant tracking system and contacted 100 applicants who had previously applied but not responded, to ask for interest related to new wages (no date of implementation or review); -Administrator or HR (human resource) Director will monitor daily for any staffing issues/concerns (no date of implementation or review). Although the facility provided the improvement plan, the plan had not been routinely reviewed for effectiveness as the plan was dated November 2020 and target dates of completion were not reviewed again until March and April 2021 four to five months after being implemented and during survey 4/12/21 to 4/22/21.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, record review and interviews, the facility failed to ensure that residents were free of unnecessary psychotropic medications for two (#118 and #76) of five residents out of 68 total sample residents. Specifically, the facility failed to: -Track hours of sleep to evaluate the effectiveness of an antidepressant being utilized as a hypnotic for the diagnosis of insomnia, for Residents #118 and #76; -Follow a physician's order to track and monitor hours of sleep, for Resident #118 and #76; -Attempt a trial discontinuation of an antidepressant being utilized as a hypnotic based on assessment for continued symptoms and effectiveness of the medication, for Resident #118; and, -Obtain a physician signature and response to the pharmacist monthly medication review recommendation, for Resident #118. Findings include: I. Professional reference [NAME] Nursing Drug Handbook 2020, Kizior, R. J. and [NAME], K.J., St. Louis Missouri 2020, pp. 1170-1172. Read in part: Classification - antidepressant. Uses: treatment of major depressive disorder; off-label: insomnia. Elderly patients are likely to experience sedative hypotensive effects. Side effects: drowsiness and occasional nervousness. Assess mental status, mood, and behavior for patients on long-term therapy. Tolerance to sedative effects can develop, usually early in therapy. II. Facility policy and procedure The Tapering Medications and Gradual Drug Dose Reduction policy, dated April 2007, was provided by the nursing home administrator (NHA) on 4/20/21 at 5:58 p.m. It read in pertinent part: The attending physician and staff will identify target symptoms for which a resident is receiving various medications. The staff will monitor for improvement in those target symptoms and provide the physician with that information. The staff and practitioner will consider tapering of medication as an approach to determining an optimal dose or determining whether continued use of a medication is beneficial to the resident. A pharmacy protocol titled Psychotropic Medication Prescribing Guidelines, dated November 2017, was provided by the NHA on 4/21/21 at 5:58 p.m. It read in pertinent part: Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used . without adequate monitoring. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Residents A. Resident #118 1. Resident status Resident #118, age 80, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included insomnia, recurrent depressive disorder, bipolar disorder and dementia with behavioral disturbance. The 2/26/21 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) of 11 out of 15. At the time of the assessment, the resident was taking daily antipsychotic and antidepressant medications. The assessment did not document the resident's use of hypnotic medications. A gradual dose reduction (GDR) of medication had been considered on 2/25/21 and was deemed contraindicated. The resident did not express symptoms of depression with a score of zero on the patient health questionnaire-9 (PHQ-9); and answered no to having trouble falling asleep, staying asleep or sleeping too much. 2. Observations and interview On 4/13/21 at 2:35 p.m., Resident #118 was observed sleeping in bed. The resident woke up as her roommate was being interviewed. Resident #118 was interviewed on 4/13/21 at 2:58 p.m., Resident #118 said the nurses think they are doctors in training, they keep messing with my medications and don't discuss changes with me. The resident denied having trouble sleeping at night. On 4/15/21 at 9:00 a.m., the resident was observed sleeping in bed. On 4/15/21 at 10:22 a.m., the resident was observed sleeping in bed. On 4/15/21 at 11:27 a.m., the resident was observed sleeping in bed. On 4/15/21 at 3:45 p.m., the resident was observed sleeping in bed. On 4/19/21 at 9:59 a.m., the resident was observed sleeping in bed. On 4/19/21 at 11:33 a.m., the resident was observed sleeping in bed. On 4/21/21 at 4:44 p.m., the resident was observed sleeping in bed 3. Record review An email communication from the facility's consulting pharmacist, dated 4/15/21 at 1:48 p.m., was provided by the NHA on 4/20/21 at 5:58 p.m. It read in pertinent part: Resident #67: Trazodone (antidepressant sedative medication) - last GDR evaluation was 7/29/20. Resident was readmitted on [DATE] (which again, restarts the GDR process). GDR evaluation was requested March 2021 and there has been no response. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #118's April 2021 CPO revealed the following physician orders: -Trazodone HCl 100 milligrams (MG) tablets; give one (1) tablet at bedtime related to insomnia.; and, -Monitor hours of sleep every shift for insomnia. A physician's visit note dated 3/25/21. The note revealed the resident was seen for Insomnia. The note read in pertinent part: On Trazodone. Has orders to monitor hours of sleep, no documentation for months . Assessment and plan: Insomnia, unspecified: chronic condition, clinically controlled, continue current regimen. New order to monitor hours of sleep placed in electronic medical record. If sleeping more than eight hours will order a gradual dose reduction of Trazodone to decrease polypharmacy and minimize risk for ADE (side effect). Review of the resident's comprehensive care plan revealed a care plan focus for insomnia. The care focus updated 3/30/21 revealed Resident #118 used psychotropic medication including Trazodone related to insomnia. Interventions included: Administer psychotropic medications, as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor hours of sleep every shift for insomnia. Consult with pharmacy and physician to consider dosage reduction when clinically appropriate. A separate care focus for insomnia, revised 1/28/21, revealed Resident #118 had insomnia and was taking trazadone. Interventions included: Determine if daytime napping interferes with nighttime sleeping. Record and monitor sleep patterns. Administer medication as ordered. The April 2021 medication record (MAR) revealed the resident received the prescribed dose of Trazodone at bedtime except for 4/2/21 and 4/7/21. -There was no documentation of why the resident had not received the bedtime dose of Trazodone, on those two nights. The order entry for tracking hours of sleep had check mark responses, but failed to document an actual number of hours the resident slept during the shifts. -Review of progress notes for 4/1/20 through 4/15/21, revealed inconsistent documentation about Resident #118's sleep patterns; and no documentation of the resident's actual hours of sleep throughout the day and night. Notes revealed the resident was napping throughout the day and evening on various occasions. -Review of certified nursing aide (CNA) documentation did not reveal any documentation for monitoring hours of sleep. 4. Staff Interviews CNA #10 was interviewed on 4/18/21 at 11:34 a.m. CNA #10 said Resident #118 takes frequent naps throughout the day. The nurses would track and notify the resident's doctor about a resident's sleeping patterns and the CNAs would notify the nurse if they observed any concerns with the resident's sleep or lack of sleep. 5. Follow-up (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 4/21/21 at 5:36 p.m. The DON said the floor nurse spoke to Resident #118's physician and a decision was made by the physician to discontinue the resident's Trazadone for a trial to see if the resident would be able to sleep without the medication. Progress notes regarding the discontinuation of the resident's Trazodone read in pertinent part: -Nurses note dated 4/19/21 at 11:59 a.m. Received order from the physician to discontinue Trazodone for diagnosis of insomnia because of resident's drowsiness in bed. -Nurses note dated 4/19/21 at 3:39 a.m. Resident is being monitored for discontinued Trazodone, no signs or symptoms of insomnia, distress or discomfort noted at this time of the nightshift. Will continue to monitor. B. Resident #67 1. Resident status Resident #67, under the age of 65, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), diagnoses included insomnia, depressive episodes, and traumatic brain injury. The 2/2/21 MDS assessment revealed the resident was severely impaired cognition with a BIMS of four out of 15. The resident had impaired communication and did not express needs with spoken words. The resident sometimes understood communication and was able to respond to simple direct communication. At the time of the assessment, the resident was taking daily antianxiety and antidepressant medications. The assessment did not document the resident use of hypnotic medications. The assessment did not document if a GDR of prescribed psychotropic medication had been attempted or not. The resident did not show symptoms of depression with a score of zero on the PHQ-9; and answered no when asked about having trouble falling asleep, staying asleep or sleeping too much. 2. Observations and interview On 4/13/21 at 9:16 a.m., Resident #67 was observed sleeping in bed. On 4/14/21 at 9:16 a.m., Resident #67 was observed sleeping in bed. On 4/14/21 at 4:15 a.m., Resident #67 was observed sleeping in bed. Resident #67 was unable to answer questions about possible sleeping difficulties. When asked if he had any trouble he made a facial grimace and shook his head from side to side. He was not able to voice an explanation of his answer. 3. Record review Resident #67's April 2021 CPO revealed the following physician orders: -Trazodone HCl 25 MG tablets; give one tablet at bedtime for insomnia, monitor hours of sleep. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's visit note dated 1/7/21, read in pertinent part: Diagnostic statement: Insomnia, unspecified. Plan: Insomnia, stable. Per nurse, resident has been sleeping well at night and appears awake and alert during the day with an occasional naps. Melatonin (supplement) 3 MG every evening at bedtime and Trazodone 25 MG every evening at bedtime. Discontinue melatonin. Continue meds, note hours of sleep per day. Goal: Member reports improvement in sleep quality. Contingency plan: Consider GDR of Trazodone Review of the resident's comprehensive care plan revealed a care plan focus for insomnia. The care focus updated 2/22/21 revealed Resident #67 had insomnia and was prescribed Trazadone. Interventions included: Administer medications as ordered. Assess the need for effectiveness of medications that promote sleep. Determine if daytime napping interferes with normal sleep. Monitor hours of sleep. The April 2021 MAR revealed the resident received the prescribed dose of Trazodone at bedtime. -There was no documentation of hours of sleep per day. -Review of progress notes for 4/15/2020 through 4/15/21, revealed inconsistent documentation about Resident #67s sleep patterns; and no documentation of the resident's actual hours of sleep throughout the day and night. -Review of certified nursing aide (CNA) documentation did not reveal any documentation for monitoring hours of sleep. IV. Other interviews Licensed practical nurse (LPN) #9 was interviewed on 4/15/21 at 1:55 p.m. LPN #9 said the nurses should track hours of sleep every shift, for any resident taking a hypnotic medication for sleep. Registered nurse (RN) #4 was interviewed on 4/19/21 at 10:04 a.m. RN #4 looked at orders for Resident #118 and Resident #76 and was unable to locate documentation of either resident sleep patterns or hours of sleep. RN #4 confirmed both residents had an order to track hours of sleep, but said the nurses were not recording the actual hours of sleep as ordered. RN #4 said she would have to check with the unit manager to see how and where they were to record the resident's hours of sleep. Unit manager (UM) #2 was interviewed on 4/19/21 10:07 a.m. UM #2 acknowledged there were orders to track the residents' sleep patterns by hours of sleep, but the nurses were not documenting the residents ' sleep patterns each shift as ordered. UM #2 said she would correct the orders so the actual hours of sleep would be recorded. The director of nursing (DON) was interviewed on 4/19/21 at 10:10 a.m. The DON said the nursing staff should track a resident's hours of sleep when a hypnotic medication like Trazodone was prescribed. She was not sure why the order had not been followed and said she would look into it.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 38503 Based on observations, record review, and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater on two of three units. Specifically, the medication administration observation error rate was 8%, or two errors out of 25 opportunities for error. Findings include: I. Facility policy The Medication Administration General Guidelines policy, updated September 2018 was provided by the nursing home administrator on 4/19/21 at 11:30 a.m. It documented, in pertinent part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications .If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from the prescriber. The need for crushing medications is indicated on the resident's orders and the MAR (medication administration record) so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate, during Medication Regimen Reviews. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. II. Professional reference MedlinePlus Lidocaine Transdermal Patch, (updated 4/16/21), retrieved on 4/28/21 from: https://medlineplus.gov/druginfo/meds/a603026.html read, in pertinent part, Never apply more than three patches at one time, and never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects. III. Observations of medication errors and staff interview Registered nurse #10 was observed preparing Resident #81's medications on 4/14/21 at 5:15 p.m. RN #10 prepared Protonix 40 mg (milligrams) one tab, Coreg 6.25 mg three tabs and Gabapentin 600 mg. The resident stated she was having trouble swallowing so RN #10 placed Resident #81's medications in a plastic sleeve and crushed them and administered them to the resident. -RN #10 said she was not aware she should not crush Protonix. She acknowledged there was no order to crush the resident's medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #11 was observed preparing Resident #14's medications on 4/15/21 at 8:47 a.m. Resident #14 had orders for Aspercreme Lidocaine 4% patch which she removed from the package and dated. When LPN #11 went to apply the patch to Resident #14's lower back, Resident #14 had an Aspercreme Lidocaine patch on from 4/14/21, at that time LPN #11 removed the patch from the resident's lower back and placed the new patch on her back. She said the evening nurse likely did not remove the patch last night at bedtime. She acknowledged the patch should only be on for 12 hours, and off for 12 hours. IV. Record review Review of Resident #81's April 2021 computerized physician orders (CPO) and medication administration record (MAR) revealed no crush order. Review of Resident #14's April 2021 MAR revealed the evening nurse signed off that she had removed Resident #14's Aspercreme Lidocaine patch at bedtime on 4/14/21. V. Staff interviews Unit manager (UM) #2 was interviewed on 4/15/21 at 10:55 a.m. She said she was told Resident #14 had her lidocaine on from yesterday 4/14/21 and it was not removed by the evening nurse at bedtime. She said the Lidocaine patch should have been removed by the evening nurse last night. She said she planned to complete education with that nurse. The director of nursing (DON) was interviewed on 4/15/21 at 2:17 p.m. She said she was made aware of the medication error rate was 8%. She acknowledged residents should have an order to crush medications and Protonix should not be crushed. She said staff should have removed Resident #14's Lidocaine patch per order. She said LPN #11 should have contacted the doctor to make him/her aware the patch had been on for 24 hours. She said she would start follow-up and provide education to the nurses with a performance improvement plan (PIP) to address crushing medications and ensure they followed orders with removing the Lidocaine patch. The nursing home administrator (NHA) and DON were interviewed on 4/22/21 at 8:13 a.m. The DON said the pharmacist should complete medication pass with the nurses routinely. She said the pharmacist had been in the last month but she had just recently scheduled the pharmacist complete medication pass with the nurses this past month. She said in addition she would have the staff development coordinator (SDC) complete medication pass with the nurses.

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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. 41032 Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures for all residents including Resident #20, #166, #117, #113, #88, #14, #151, #131, #144, #153 #114, #146, #111, and #127 and four resident council members. Specifically, the facility failed to ensure resident food was palatable in taste, texture and temperature; within posted meal times. Findings include: 1. Facility policy The Food and Nutrition Services policy, dated October 2017, was provided by the nursing home administrator (NHA) on 4/20/21 at 8:35 a.m. It read in pertinent part, Each resident is provided with a nourishing palatable, well balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. -Meals will be provided within 45 minutes of either resident request or scheduled meal times; -Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, so food appears palatable and attractive, and it is served at safe and appetizing temperatures. A. Resident interviews Residents were identified as interviewable by the facility and assessment. Resident #20 was interviewed on 4/12/21 at 2:05 p.m. Resident #20 said the food always comes late and cold. Resident #166 was interviewed on 4/12/21 at 3:59 p.m. Resident #166 said the food was tasteless and cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #117 was interviewed on 4/12/21 at 5:14 p.m. Resident #117 said the food portions are too small; the resident described receiving a small spoonful of mixed vegetables that could be eaten in one bite and getting two pieces of asparagus at dinner. If you order the fruit plate you better order two or you will go hungry, because the kitchen only gives you a couple of pieces of fruit. Resident #117 said most of the time food was ice cold; I ordered a hamburger for dinner and it was ice cold; I just couldn't eat it; no one offered to get me something else or even heat it up. The resident ordered a salad for lunch and said there were actual pieces of ice on the lettuce. Part of the problem with dinner service was that it was served so late, food was cold by the time they got to the residents. Dinner was supposed to be served between 6:00 p.m. and 6:15 p. m. and on most evenings it is not served until 6:30 p.m. or even 7:00 p.m. Besides the food being cold, staff do not give us enough time to eat and digest food. Within 10 or 15 minutes of getting your tray late, the staff came back to pick up the tray, so they can get residents ready for bed. Resident #113 was interviewed on 4/12/21 at 5:20 p.m. Resident #113 said we were served a lot of chicken and pasta. The food was served cold. By the time it gets here, it's cold, because there are not enough nursing aides to deliver it timely. Resident #88 was interviewed on 4/12/21 at 6:39 p.m. Resident #88 said the meat was tough and described the food as being gross. Resident #14 was interviewed on 4/13/21 at 9:33 a.m. Resident #14 said, I can't eat the food because it has no taste and no seasonings. The staff always forget to serve seasons for the food. Resident #14 said she liked sugar on her cereal but did not get the sugar packets on the breakfast tray, so she did not eat the cereal. Staff did not ask her why she was not eating the cereal or what substations she might like. Resident #14 said she did not want to complain; she was often hungry, worried she might start losing weight and rarely got snacks between meals. Resident #151 was interviewed on 4/13/21 at 9:38 p.m. Resident #151 said Resident #14 was correct in saying the food did not taste good and said she also felt hungry after a meal because she did not like the food and was often unable to eat it. Resident #157 said snacks were only provided on occasion. Resident #131 was interviewed on 4/13/21 at 11:15 a.m. Resident #131 said the food looked gross, like slop and it was usually cold. The other night, I had shrimp with too much garlic and burned my mouth; I end up eating a lot of hamburgers. Resident #144 was interviewed on 4/13/21 at 12:30 p.m. Resident #144 said the food was not that good. Resident #153 was interviewed on 4/13/21 at 2:58 p.m. Resident #153 said the food was not good or flavorful. Resident #114 was interviewed on 4/13/21 at 5:11 p.m. Resident #114 said I didn't eat lunch because it looks gross. I just left it and I ' ll eat dinner when it gets here. Resident #146 was interviewed on 4/13/21 at 5:38 p.m. Resident #146 said the food was terrible; the salads and fruit plates were safe; but I am getting tired of salads and fruit plates. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #111 was interviewed on 4/14/21 at 1:55 p.m. He said there was nothing that could be done about the temperature of the food, until they got a warmer box. He said it took about five to 10 minutes to load the cart, then five to 10 minutes to wheel it to the hall, then another 10 minutes to unload the trays. He said the staff always left the cart door open. He said it took a long time to get assistance (cross-reference F677 for eating assistance). He said the staff dropped his tray off in his room and told him they would come back. He said he did not like for them to place food in front of him without the ability to eat it. He said he had to look at the food for around 15-20 minutes. He said they would then give him the meal cold. Resident #127 was interviewed on 4/15/21 at 10:16 a.m. He said his meal intake depended on the meal. He said the food arrived at 11:30 a.m. to 12:00 p.m. and they did not feed him until around 1:30 p.m. (cross-reference F677). He said the food was always cold. II. Meal observations and interviews Dinner service on the 900, 1000, 1100 and 1200 halls was observed on 4/12/21 from 5:30 p.m. to 7:35 p.m. At 6:45 p.m., the residents were still waiting for dinner to be served. The certified nurse aides said the dinner trays were late and they usually arrived between 6:15 p.m. and 6:30 p.m. -At 6:44 p.m., several residents from the 900 hall were observed asking staff where dinner was and why it was so late. -At 6:51 p.m., a resident was observed at the kitchen door asking what happened and why dinner was so late. The kitchen staff told the resident they ran out of the potpie menu item and they were making more now. -At 6:57 p.m., dietary aide (DA) #1 was observed telling staff and residents on the 1000 hall that dinner was late tonight. -At 7:03 p.m., Resident #77 was observed waiting for her meal. Resident #77 said she did not like to eat past 7:00 p.m. -At 7:03 p.m., dinner trays arrived and were served to the residents in the 900 hall. -At 7:08 p.m., the dinner trays arrived and were served to the residents on the 1100 hall. -At 7:15 p.m. dinner was served to the residents on the 1200 hall. -The last tray was delivered to a resident on the 1200 hall at 7:36 p.m. The NHA was interviewed on 4/12/21 at 7:40 p.m. The NHA said the last tray being delivered at 7:30 p.m., was the normal schedule. Resident #111 was observed in his room on 4/14/21 at 12:28 p.m. His lunch tray was on the bedside table. At 12:39 p.m. he left his room and wheeled down the hallway. Therapy staff talked to him in the common area. At 1:11 p.m., the resident went back down to his room. He told the staff he was ready when they were. Staff began to set up his tray at 1:22 p.m (cross-reference F677). The staff did not offer to reheat any of the food items which was observed for 52 minutes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident council member's interview An interview was conducted with the resident council president and three cognitively intact active members of the resident council on 4/20/21. The members said that the regular group resident council was not occurring due to COVID-19 restrictions for group gatherings. The resident council president and active members said they did hear from their peers on their unit with questions and concerns during small group gatherings. All four members agreed there were concerns with the food. Residents agreed: -The food did not always taste good; -The kitchen did not offer additional seasonings on the tray so residents could adjust the meal for individual tastes; -There was not always enough staff to serve meals timely, dinner was served very late; -Meals were often cold when delivered; -There needed to be more variety in the foods offered especially on the alternative menu; and, -Vegetable portions were small. IV. Test tray On 4/21/21 at 12:04 p.m., a test tray, regular diet was evaluated immediately after the last resident had been served a lunch tray on the 200 hall. Both meal entree choices were tested . The test tray was plated at 11:39 a.m., and left the kitchen at 11:45 a.m. The test tray with the resident trays arrived at the 200 hall at 11:46 a.m.; the test tray was delivered at 12:01 p.m., being the last tray to come off the room tray delivery cart. Four surveyors evaluated the regular diet test tray. The test tray consisted of the two main entree choices. The first meal choice: beef brisket, mixed vegetables and wild rice. The second meal choice consisted of cornflake crusted chicken, green beans, and egg noodles. The dessert was chess pie (a sweet sugary custard type pie). The district dietary manager (DDM) took the temperature of the food just as it was delivered. Food temperatures were as follows: -Beef brisket 123.1 F; -Wild rice 127.0 F; -Green beans 128.0 F; -Cornflake crusted chicken 126.0 F; -Egg noodles 120.2; and, (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mixed vegetables 118.0 F. The following comments were made after test tasting this tray: -The beef brisket was grisly; the chicken was dry; the noodles lacked seasoning; the green beans were very mushy, losing consistency and had a metallic taste; and the pie, while tasty, left a greasy film on the roof of the mouth. V. Staff interviews The DDM was interviewed on 4/21/21 at 12:03 p.m. The DDM said the facility had started a food committee where they encouraged residents to voice food requests. The residents were encouraged to pick new menu items to replace less desired menu options. They were working with residents to improve food quality. Dietary manager (DM) #1 was interviewed on 4/22/21 at 9:10 a.m. DM #1 said ideal food temps at start of service from the steam table should be 150 degrees F minimum, so hot foods would be hot when served to the residents. Ideal temperatures for hot foods served to the residents would be 140 degrees F. The facility was having a hard time keeping the hot food hot when serving room trays since having to plate everything from the main kitchen steam table and then transport the trays to the resident rooms from the kitchen. The rolling food carts were not insulted and do not hold food temperatures for long. Prior to March 2020 and COVID-19 pandemic restrictions, the kitchen cooked the meals in the main kitchen and transported the food to the satellite kitchens where food was held in the steam table at appropriate temperatures for hot foods, until the food was served directly to the resident. Residents ate in the dining halls attached to the satellite kitchens; foods were plated and taken directly to the resident's table. The facility was resuming dining in the satellite kitchen's on a small scale with social distancing which allowed for one resident to a table and six feet between the residents.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41032 Based on record review, observations, and staff interviews, the facility failed to ensure food was prepared, distributed, and served under sanitary conditions in the main kitchen. Specifically the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. Findings include: I. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view It reads in pertinent part: 6-501.12 cleaning, frequency and restrictions. Physical facilities shall be cleaned as often as necessary to keep them clean. -4-601.11 equipment, food-contact surfaces, nonfood-contact surfaces, and utensils shall be clean to sight and touch; -4-602.13 nonfood-contact surfaces shall be cleaned at a frequency necessary to preclude accumulation of soil residues. II. Facility policy and procedure The Environment policy, dated September 2017, was provided by the nursing home administrator (NHA) on 4/20/21 at 8:35 p.m., it read: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. III. Observations The main kitchen was observed on 4/20/21 at 11:00 a.m. The following was observed: -The wire-shelving unit where the coffee and water/juice pitchers were stored was soiled with dust and blotches of a thick white dried substance clinging to the rungs of the wire shelves. The wire shelves were open with no barrier between the wire rungs and the pitcher that were stored top side down directly in the shelving unit. There were two brown plastic milk crates on the shelving unit that held the lids for the pitchers. The crates were very dusty inside and out; both were coated with a whitish/blackened caked substance. When the crates were removed for cleaning there was an obvious layer of dust covering the wire rungs of the shelving unit. There was less dust where the crates had been placed. -The juice machine station was soiled with spots of dried juice. The shelf under the juice dispenser stored boxes of juice. Every juice box was soiled with dried juice and the front of the shelf had a layer of cake crumbs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Several of the coffee pitchers had brown stains on the outside. -The wall beside the coffee machine station and above the trashcan was soiled with several dried brown spots; there were coffee grounds on the wall and on the casing covering the electrical wiring. -The wall outlets were covered with fine dust. -The floor at the wall edges especially behind the oven, the coffee machine and the juice machine were soiled with a black substance and crumbs. The kitchen was observed again on 4/22/21 at 8:45 p.m. The following was observed: -The areas mentioned in the above observation remained in the same condition. -Tea was steeping in a large stockpot without a covering and no staff nearby to make sure the tea remained free from possible floating debris. -Two clear eight-quart containers stacked together in a clean storage area had a large amount of moisture between the containers. When separated the moisture build up dripped down the side of the containers. V. Staff interviews The district dietary manager (DDM) was interviewed on 4/20/21 at 11:15 a.m. The DDM said kitchen staff were to clean up their work areas after each meal service. The floors were swept and moped as needed and at the end of the day. Deep cleaning of the kitchen including the floors was done weekly. Dietary manager (DM) #1 was interviewed on 4/22/21 at 9:10 a.m. DM #1 acknowledged the wire rack that stored the clean coffee and water/juice pitchers rack should be cleaned regularly to maintain sanitary conditions; especially since the open end was stored directly on the wire rack. The DM said the juice station was to be cleaned every night to remove juice spills and any food debris. Floors were to be swept as needed during the day with a thorough sweeping and mopping being done on a nightly basis. The floors were deep cleaned every week. The DM said dust and derbies in the kitchen could be a potential contamination hazard and the steeping tea should have been covered. The DM acknowledged the floors, appliances, and storage shelving required cleaning.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43134 Based on observations, record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for residents to include two (#13 and #114) residents out of 68 sample residents and the facility. Specifically the facility failed to: -Ensure proper infection control practices were followed during tracheostomy care for Resident #13; -Ensure urinals are cleaned and stored in a sanitary manner for multiple residents; and, -Staff practiced hand hygiene after providing incontinence care for Resident #114. I. Professional reference The Center for Disease Control and Prevention (last updated on January 30, 2020) Hand Hygiene in Healthcare Settings, When and How to Perform Hand Hygiene, https://www.cdc.gov/hai/pdfs/ppe/ppeslides6-29-04.pdf, retrieved on 4/28/21. It read in pertinent part to, clinical indications when to perform hand hygiene include before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient, after contact with blood, body fluids or contaminated surfaces. II. Facility policies and procedures The Infection Prevention and Control Program policy and procedure, dated January 2020, revised November 2020, provided by the NHA on 4/19/21 at 5:47 p.m. read in pertinent part: -An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -Important facets of infection prevention include identifying possible infections or potential complications of existing infections; educating staff and ensuring that they adhere to proper techniques and procedures; and, implementing appropriate isolation precautions when necessary. -Training and education to include disease transmission prevention; standard and transmission-based precautions; procedures to follow when personal protective equipment is used. The Tracheostomy Care policy and procedure, dated 2001, revised august 2013, provided by the NHA on 4/21/21 at 2:52 p.m., read in pertinent part: -Tracheostomy care should be provided as often as needed. -Put exam gloves on both hands. -Remove old dressings, wash hands. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Open tracheostomy cleaning kit, set up supplies on sterile field. -Maintaining sterile field, pour equal parts hydrogen peroxide and normal saline in one compartment of opened kit. Pour normal saline in another compartment. -Put on sterile gloves, gently remove the inner cannula. -Soak the cannula in hydrogen peroxide/saline mixture. -Clean with brush, rinse with saline and dry with pipe cleaners. -Remove gloves, wash hands, put on fresh gloves and replace the cannula and lock in place. Site and stoma care: -Apply clean gloves. -Clean the stoma with two peroxide-soaked gauze pads (using a single sweep for each side). -Rinse the stoma with saline-soaked gauze pads (using a single sweep for each side). -Wipe with dry gauze (using a single sweep for each side). -Allow to air dry or wipe with clean dry gauze. -Remove neck ties and replace with clean ones. -Apply a split gauze pad around the insertion site. The PPE policy, last revised March 2020, was received by the Nursing home administrator (ANHA) on 4/20/21 at 10:00 a.m. It read in pertinent part to, staff needed to wear gloves when they were performing a procedure that was in contact or could be in contact with resident bodily fluids to protect themselves from contamination. The hand hygiene policy, last revised on 3/1/2020 was received by the assistant nursing home administrator (ANHA) on 4/20/21 at 10:00 a.m. It read in pertinent part to, hand hygiene needed to be performed after contact with a resident and or bodily fluids as well as when removing gloves. III. Observations of breaks in infection control On 4/12/21 at 1:00 p.m. there were two unknown residents seated in the common area on Golden Gate unit, one had her mask below her nose and the other resident had his mask below his chin. They were talking with a staff member and he did not ask them to reapply their masks correctly. -At 5:11 p.m. room [ROOM NUMBER] had a stop sign on the door that said stop isolation precautions. There was no signage indicating what type of isolation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/13/21 at 8:30 a.m. a nurse was seen preparing to enter isolation room [ROOM NUMBER]. She did not sanitize her hands and applied a gown and gloves then entered the room. -At 8:38 a.m. there was a urinal, containing urine, on the overbed table next to the resident ' s bed in room [ROOM NUMBER]. There was a glass containing ice water next to the urinal on the table. -At 8:40 a.m. LPN #1 was observed during tracheostomy (trach) care for Resident #13. She sanitized her hands and applied a gown and gloves. She then typed on her computer keyboard and used the computer mouse then swiped and typed on a tablet screen. The resident had thick yellow sputum coming from the trach and pooled on his chest below his trach. She entered the resident ' s room, picked up his urinal and emptied it. She donned new gloves and removed items he had on his overbed table. She used Versa Sure bleach wipes, with a dwell time of two minutes, to clean the top of the overbed table. She did not allow the surface to dry and placed the package of trach suctioning supplies on top of the table, as well as the tubing connected to the suction machine, she then turned the machine on. She placed a bottle of sterile water on the table that she obtained from on top of a nearby cabinet. She then retrieved the package of sterile gloves from the tray and placed it on the wet surface of the overbed table and donned the gloves. Wearing the sterile gloves, she opened the bottle of sterile water, picked up the sterile suction catheter and connected it to the suction tubing. She then entered the tracheostomy with the suction catheter but could not suction any sputum. She removed the plastic inner cannula of the trach. She suctioned the trach then curled the sterile catheter into her left unclean gloved hand. She then took the yellow sputum covered inner cannula to the handwashing sink in the room, rinsed it, and shook it a couple times in the air. She then went to the suction tray, held the inner cannula over the tray and poured sterile water through the middle of it and replaced it in his trach. With the same sterile gloves on she moved the overbed table, opened the night stand drawer and touched items in the drawer looking for gauze pads. She then went to a cabinet at the foot of the bed, that had trach supplies on top of it, and moved several of those items. The resident asked the nurse are you sure it's in there, I don't think it snapped. She then obtained a hard plastic ([NAME]) suction piece, attached it to the suction tubing and suctioned the thick yellow sputum off his chest. She wiped the area with dry gauze, and replaced the oxygen humidification mask over his trach. She placed the soiled [NAME] on the unprotected surface of the overbed table. She then removed the soiled drain sponge surrounding the trach stoma (opening in the skin). She wiped the skin below the trach with a dry gauze, she did not clean the area with peroxide-soaked gauze or rinse it with saline-soaked gauze. She loosened the straps of the trach collar and replaced the drain sponge then retied the collar straps, she did not change the collar. When she was done she disconnected the [NAME] from the suction tubing and disposed of it in the trash can. She did not clean the overbed table surface and replaced his water pitcher, beverage glasses, and his urinal on top of the table. Review of the nursing skills validation checklist for tracheostomy care dated 6/6/2020 revealed LPN #1 was checked off on her skills with a return demonstration along with 15 other nursing staff members. There was no skills checked off for LPN #1 after 6/6/2020. -At 11:30 a.m. Resident #13 had his urinal on the overbed table next to a drinking glass. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 11:58 a.m. a resident was seen exiting her room in the 2300 hall. She did not have her mask on. She approached a cart sitting in the hallway that had beverages in pitchers for the lunch meal. She picked up two different pitchers and poured the drinks into her personal cup touching the spouts of the pitchers to the edge of her cup. -At 1:45 p.m. Resident #13 had his lunch tray on his overbed table. He had coughed several times and there was thick yellow sputum coming from his trach and lying on his chest below the trach. The nurse came into the room to raise the head of his bed further so he could eat and did not remove the sputum from his chest or suction his trach. On 4/13/21 at 4:17 p.m. certified nurse assistant (CNA) #9 and CNA #21 entered Resident #114 ' s room and donned gloves and stood on each side of the resident ' s bed and provided incontinence care. When the CNA ' s completed the task the resident asked to transfer to her wheelchair. CNA #9 and CNA #21 continued to wear the gloves that were used to provide the resident ' s incontinence care. CNA #9 moved the mechanical lift from the resident ' s bathroom to the side of the bed where the resident was sitting and used the control of the lift to position it. CNA #21 moved the resident ' s wheelchair using the control the resident used. CNA #9 opened the resident ' s room door to the hallways. On 4/14/21 at 11:10 a.m. Resident #13 was seen lying in bed with the head of the bed elevated, there was thick yellow sputum coming from his trach and it had gathered on his chest below the trach. He said he was not necessarily comfortable with the nursing staff taking care of his trach but he did not elaborate. -At 4:36 p.m. Resident #13 was seen lying in bed, with his eyes closed. There was thick yellow sputum coming from his trach with a streak of red down the middle of it. His urinal, containing urine, was lying on his overbed table next to an ice cream cup, and a glass with water in it. When the nurse saw the surveyor exit the room she went in and cleaned the sputum from his trach. On 4/15/21 at 9:03 a.m. Resident #13 was seen in bed, there was thick yellow sputum coming from his trach and was on the gauze below it. His urinal was on the overbed table positioned next to a glass of juice he was drinking. -At 10:30 a.m. an observation of trach care was done with LPN #2 and the staff development coordinator (SDC) in attendance as well. LPN #2 used alcohol based hand rub (ABHR) and applied gloves. She used a bleach wipe on the overbed table and did not allow it to dry and placed the tray of trach cleaning supplies on it. She removed the gloves, applied a gown, and used ABHR then opened the tray of supplies. She obtained a bottle of Peroxide and sterile water from on top of the cabinet at the foot of the bed and placed them on the table next to the tray. She opened the tray and applied the sterile gloves from inside the tray then spread the sterile barrier pad on the table. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She then picked up the gauze, the cleaning brush, and the suction tubing from the tray and placed them on the sterile barrier. With the sterile gloves on she picked up the bottle of Peroxide and poured the solution into a section of the tray and repeated the same with the sterile water. While still wearing the sterile gloves she then turned to the resident and grasped the oxygen humidification mask to remove it, then removed the soiled inner cannula of the trach and placed it into the peroxide solution. She used the brush supplied in the tray to clean down the middle of the cannula then placed the cannula in the sterile water to rinse it, shook it, dried it with a gauze pad and placed it back into the trach. With the sterile gloves still on she opened a container of normal saline and soaked gauze pads with the saline to clean under his trach. She then attached the suction tubing and suctioned the trach. At this point she removed the sterile gloves and applied a pair of regular gloves. She used bleach wipes and cleaned the overbed table and placed two paper towels on top of the wet surface of the table then placed his urinal on top of the towels next to a juice container, a drinking glass, and a water pitcher. -At 12:09 p.m. a urinal was seen on an overbed table in room [ROOM NUMBER]. On 4/19/21 at 10:05 a.m. social services (SS) #2 was seen entering quarantine room [ROOM NUMBER] without sanitizing her hands or donning a gown or gloves. She leaned on the resident ' s overbed table, with her bare arms, talking to him and documenting on a piece of paper. She then leaned on the handles of his walker with her bare arms touching both handles. His urinal was hanging on his walker below the seat and her pant leg was touching it. She exited the room and did not sanitize her hands and walked down the hall. She said she did not apply a gown and gloves because the resident was her roommate that lived with she and her husband. She said she was around him all the time so she did not feel the need to don the gown and gloves even though he was admitted after a hospital stay and was in quarantine. On 4/19/21 at 12:58 p.m. Resident #13 had his urinal on his overbed table next to a juice glass, a water glass, and an ice pitcher. On 4/20/21 at 11:00 a.m. the wound registered nurse (WRN) was observed during pressure ulcer wound care for Resident #127, Cross-reference F686.There was an individual who said she works for the company that observed the wound care as well. The wound care orders read: 1) Coccyx/sacrum-clean wound with Dakins soaked gauze, clean the peri-wound with Dakins soaked gauze and pat dry, apply skin prep to the surrounding skin, soak Kerlix with Dakins and pack the wound, cover the wound with an abdominal (ABD) pad and tape twice daily. 2) Right buttock-clean with normal saline, pat dry, apply skin prep to the surrounding skin, apply Santyl (a medication that removes dead tissue from wounds) to the wound and cover with foam dressing twice daily. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The WRN gathered supplies from the treatment cart outside the room. She placed a pair of stainless steel scissors on the surface of the treatment cart without placing a clean barrier in between the cart surface and scissors . She cleaned the top of an overbed table with a bleach wipe with her bare hands and placed wax paper on the table to place the supplies on. She used the scissors to cut pieces of wide tape and placed them on the table. She placed a bottle of Dakin's solution, an opened roll of Kerlix gauze, 4x4 gauze pads, plastic cups, packages of Betadine soaked swabs, an ABD pad, skin prep pads, cotton tipped applicators, normal saline ampoules, and a foam dressing on the table. She then cleaned the scissors with an alcohol pad with her bare hands and placed them on the table as well. She entered the room with the table, washed her hands, turned the faucet off with the paper towel she dried her hands with. She applied gloves and removed the two dressings on the resident ' s bottom. The coccyx/sacral soiled dressing had clear/reddish (serosanguinous) and brownish drainage on it. The right buttock wound dressing had a scant amount of serosanguinous drainage on it. The coccyx/sacral wound was large and deep. The wound bed was beefy red with an area of brownish tissue at its deepest point in the center. There was a whitish piece of tissue hanging from the left edge of the wound and the tissue to the right upper corner, just next to the edge, was brownish in color. The nurse removed her gloves and washed her hands and again shut the faucet off with the paper towel she dried her hands with. She applied clean gloves and moistened the old packing inside the wound with normal saline to remove it, as it had dried out. The old packing had serosanguinous and brownish drainage on it and had an unpleasant odor. The nurse removed her gloves and washed her hands and repeated the same process when she turned the faucet off. She donned clean gloves, poured Dakin's solution into a plastic cup and used 4x4 gauze pads soaked with the solution to clean inside the wound. With each wipe the gauze came out with reddish brown drainage. The nurse then used cleansing wipes to remove brown bowel movement (BM) from below the wound. She removed her gloves, washed her hands in the same manner and donned clean gloves. She then cleaned the skin around the wound with gauze soaked in Dakin's solution, then cleaned the wound bed again after cleaning outside the wound, potentially contaminating the wound bed. She then picked up the bottle of Dakin's solution wearing the same gloves to pour the solution into a plastic cup. She patted the skin dry around the wound, removed her gloves, washed her hands again in the same manner and donned clean gloves. The right buttock wound was circular and covered in black tissue. She cleaned the wound with normal saline and patted it dry. She applied skin prep to the surrounding skin. She then wiped more BM from below the coccyx/sacral wound and next to the right buttock wound. She removed the gloves and washed her hands again in the same manner and donned new gloves. She again applied skin prep to the surrounding skin and to the skin surrounding the large wound as well. Wearing the same gloves she reached into the pocket of her uniform top searching for more packets of skin prep. She opened the package containing the foam dressing and used her gloved finger instead of an applicator to apply a small amount of Santyl to the center of the foam pad then placed the dressing onto the right buttock wound. She did not apply the medication to the wound surface. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She reached into her pocket to obtain a black marker to date the foam dressing and placed the marker on the chux pad on the bed. She washed her hands in the same manner and donned clean gloves. She applied the large tape strips to the edges of the ABD pad, covered the coccyx/sacral wound and dated the pad. She did not pack the wound with the Dakin's soaked Kerlix as the physician order read. Cross-reference F686 The WRN placed the marker on the table and gathered up the supplies, folded them into the wax paper, and discarded them into a red bag. She placed the bottle of Dakin's solution and the pair of scissors onto the bare table top. The unknown company employee who observed the wound care wiped off the bottle of Dakin's solution with a bleach wipe and placed it in a drawer of the treatment cart then used the same bleach wipe to clean the scissors and the overbed table that was used in the room. She placed the scissors on the unprotected surface of the treatment cart. IV. Interviews CNA #21 was interviewed on 4/13/21 at 4:45 p.m. She stated she wore the gloves until she was done providing all the cares for the resident before she left the room and then used hand sanitizer as required when she removed her gloves. LPN #2 was interviewed on 4/15/21 at 11:00 a.m. She said she had received skills training regarding trach care but she could not remember when the last time was. She said when she worked on a different hall and was unfamiliar with a resident that had a trach she would contact the SDC to receive instruction on that particular resident. She was unaware of the breaks in infection control during the trach care provided to Resident #13. The SDC was interviewed on 4/15/21 at 11:10 a.m. She said she was responsible for providing training to the nursing staff on tracheostomy care. She said she did yearly check offs where the nurses had to do a return demonstration of competencies in those areas. She said she also conducted spot checks periodically especially when new admissions arrive. The facility uses a respiratory company to help with trach management and they educate staff as well. She said the nurses were supposed to provide trach care every shift and as needed. She said she told them to allow the resident to cough out secretions if they are able because frequent suctioning can cause trauma. She said she observed the breaks in infection control when LPN #2 provided trach care to Resident #13. She said the type of inner cannula Resident #13 had was a Shiley and she thought those were disposable and it was printed on the cannula itself that it was not to be cleaned. She said the nurse should not have cleaned the inner cannula but should have thrown it away and inserted a new one. She was made aware of the observation LPN #1s trach care procedure on 4/13/21. She said she had not watched LPN #1 lately but when she came back to work she would talk with her. She said it was evident that she needed to re-educate with both LPNs. She later said the respiratory therapist told her the inner cannula is one that only needs to be changed every three days and she said she was unaware of that and no order had been put in for the nurses to change it routinely. She said an order would be put in so the nurses knew to change it every three days because they had not been doing that and there was no way to tell when it had been changed last. (continued on next page)

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	04/22/2021

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.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The WRN was interviewed on 4/20/21 at 12:00 p.m. She said she used the scissors that were in the treatment cart for all wound dressing changes. She said well, I disinfect them when I use them by wiping them with an alcohol pad. She said the facility had disposable scissors she could use but she had not considered using a separate pair for each resident. She was unaware she did not pack the resident's coccyx/sacral wound per the physician's order. She said she could do it when he was back in bed. She was unaware of the breaks in infection control during the wound care. The DON was interviewed on 4/21/21 at 11:30 a.m. She said she was made aware of the breaks in infection control during trach care for Resident #13. She said LPN #2 had reached out to the respiratory therapist and asked him to provide her more training on trach care because she wanted to be sure she was doing it right. The DON said they would provide education to both nurses that were observed during trach care. She said they would also set up re-trainings for the nursing staff with the respiratory therapist. She said when she was made aware of the observation of wound care with the WRN, that nurse was removed from the floor and a corporate nurse took over wound care. The DON was interviewed again on 4/21/21 at 4:40 p.m. She stated gloves used to provide resident incontinent by CNA ' s or nurses, needed to be discarded properly and then the staff needed to perform hand hygiene before other surfaces were touched. The DON was interviewed a third time on 4/22/21 at 8:30 a.m. She said male resident urinals should not be placed on the overbed tables next to food or drinking items. She said some residents prefer it to be on the table but she said it was an infection control issue and she would provide education to staff and residents to place the urinals in a different location to eliminate the potential for cross contamination. She said the drink cart that was brought up to the second floor before the meal carts arrived should not be left in the hallways and available to the residents to help themselves to drinks. She said she would figure out an area on the second floor to store the drink carts until staff were ready to pass the beverages to the residents. She said there were areas not being used where the carts could be kept. She said SS#2 who entered quarantine room [ROOM NUMBER] should have donned the appropriate PPE regardless whether he was in the same household as she. The DON said she will provide education to the staff member regarding proper PPE to be donned prior to entering the resident room. V. Facility follow up Mandatory education for Peri-Care and Incontinent Care for CNAs and Nurses, was received on 4/22/21 at 8:05 a.m. for eight staff members that were taking care of the resident ' s in the 1200 ' s hall of Golden Gate. Eight pieces of paper were signed by the staff that received the education, that explained staff will change their gloves and perform hand hygiene after peri-care before other surfaces are touched. As well as they completed an online course with a competency check off with the Staff development Coordinator (SCD). On 4/22/21 at 9:00 a.m. the SDC provided a copy of the eLearning educational activity for tracheostomy tube care and cleaning completed by LPN #2 on 4/19/21. She also provided a copy of the same training completed by LPN #1 on 4/20/21. (continued on next page)

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	065146	A. Building B. Wing	04/22/2021

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 9:08 a.m. the DON provided documentation of education to SS #2 per phone, as she was not in the facility at this time, related to donning the appropriate PPE prior to entering a quarantine room regardless whether it was a family member. She said SS #2 was off today and when she returned she would be required to perform a return demonstration of appropriate donning and doffing of PPE. She also said at this time the unit managers were making rounds to all male residents who use urinals providing education and updating care plans. -At 9:17 a.m. the DON said all care plans on the Eldorado unit had been updated for the male residents that used urinals. VI. Facility Covid-19 status At the beginning of the survey on 4/12/21 the facility did not have any Covid-19 positive residents or staff members. At the end of the survey on 4/22/21 the facility notified the survey team of a positive staff member after being notified of a vendor that had tested positive. 40221