STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065202	A. Building B. Wing	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Healthcare Center	1599 Ingalls St Lakewood, CO 80214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observations, interviews, and record review, the facility failed to ensure respect and dignity during resident to resident interactions in three (#50, #36, and #2) of three out of 32 sample residents. The facility failed to ensure Resident #50 had a dignified living experience. The facility failed to address complaints made by Resident #50 regarding negative comments and name calling being said to her by Resident #20 since October 2020. Resident #20 made comments regarding Resident #50's weight, which weretwo-ton, fat, and lazy. When Resident #50 was called these names, it made her feel self-conscious about her weight, humiliated, was embarrassing in front of her friends, and made her feel less of herself. The facility failed to ensure Resident #36 was not subjected to racially insensitive comments made by another resident, which in turn was hurtful and made him feel angry, hurt, discriminated against, and awful bad. In addition, the facility ensure staff were knocking on doors before entering. Findings include: I. Resident status A. Resident #50 status Resident #50, age 41, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included depression, anxiety, and obesity. The 4/14/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) assessment score of 15 out of 15. The resident required extensive assistance for activities of daily living. The resident had no behaviors. B. Resident #20 status Resident #20, age 87, was admitted on [DATE]. According to the August 2021 CPO, diagnoses included dementia and stroke. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2021
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F 0550 Level of Harm - Actual harm Residents Affected - Few	The 6/1/21 MDS assessment revealed the resident had a moderate cognitive impairment with a BIMS assessment score of 11 out of 15. The resident required extensive assistance for activities of daily living. It indicated the resident had no behaviors. II. Resident #50 interviews and observation Resident #50 was interviewed on 8/11/21 at 2:20 p.m. She said Resident #20 calls her two-ton. She said Resident #50 will also call her fat and lazy. She said when this happened it humiliated her as she was self-conscious about her weight. She said staff was aware of this situation but nothing had been done. She said this had been happening since October 2020. During an interview with Resident #20 on 8/12/21 at 9:46 a.m., the resident referred to Resident #50 as two-ton. She said the resident had certified nurse aides in her room for an excess amount of time because she was talking to them and that took time away from the rest of the residents. The resident was interviewed again on 8/13/21 at 5:41 p.m. She said she had an interaction with Resident #20 earlier in the day in the smoking area. She said Resident #20 yelled two-ton repeatedly while Resident #50 was being pushed inside by the life enrichment assistant (LEA) #2. She said LEA #2 told her to ignore Resident #20 and not give Resident #20 a reaction. She said she did not file a grievance but told the social worker (SW) who said he would come by later in the day to talk. She said the interaction was embarrassing as it happened in front of her friends and that it made her feel less of herself. The resident was interviewed on 8/17/21 at 2:21 p.m. She said the SW never came by following the incident with Resident #20 on 8/13/21. III. Record review -Review of Resident #50's and Resident #20's medical record failed to show any evidence that the negative comments were addressed. IV. Staff interviews The LEA #2 was interviewed on 8/17/21 at 9:37 a.m. He said that on 8/13/21, he was pushing Resident #50 in the smoking area when Resident #20 began to yell two-ton repeatedly. He said he told Resident #50 to ignore Resident #20's comments and name calling and not to give her attention. He said Resident #20 makes negative comments to a few of the residents at the facility. Certified nurse aide (CNA) #3 who worked with the resident on a regular basis was interviewed on 8/17/21 at 2:10 p.m. She said Resident #20 called Resident #50 negative names almost daily. She said the nursing home administrator, director of nursing, and social worker knew about this but that nothing had been done. The SW was interviewed on 8/17/21 at 3:30 p.m. He said he had spoken to Resident #20 about her behaviors but that he could not tell her what she can or cannot say to other residents. He said Resident #50 had agreed to move to a new room in order to decrease interactions with Resident #20. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	He said he was made aware of these negative interactions between the residents a week prior. He said that Resident #50 reported to him that the name calling made her uncomfortable and self conscious as she was already self conscious about her weight and these interactions did not make her feel good. The DON was interviewed on 8/17/21 at 3:35 p.m. She said Resident #20 had been calling Resident #50 negative names for a few months. She said she heard the name calling on one occasion. She said she immediately talked to Resident #20 about it but it continued. 20287 V. Resident #36 A. Resident status Resident #36, age 91, was admitted on [DATE]. According to the August 2021 CPO diagnoses included, malignant neoplasm (cancer) of colon, and multi system degeneration of the autonomic nervous system. The 6/15/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. The resident was independent in all self care areas. The resident had no behavior issues. B. Resident interview Resident #36 was interviewed on 8/11/21 at 10:33 a.m. The resident said he could not relax living here at the facility. He said he had lived at the facility for the past five years and has had six different roommates. He said Resident #1 used to be his roommate, however, he moved approximately six months ago. Resident #1 was moved because he was making racial comments and name calling to him. The name calling was in regards to using the N word (considered a racial slur) to an African American male resident. He said when he was moved, he was moved directly across the hall from his room, and now he continued to use the N word toward himself and his current roommate. Resident #36 went on to say that the comments made him angry, and it was hurtful and made him feel awful bad and he did not understand why the facility had not done anything about this problem. He said the staff were aware and he did not like being treated this way, he feels he was discriminated against. C. Resident #1 Resident #1, age 93, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included type two diabetes, dementia, coronary artery disease, hypertension, cataracts and dry eye syndrome with bilateral lacrimal glands. The 5/5/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief mental status (BIMS) score of two out of 15. The resident required limited assistance of one person for bed mobility, transfers, bathing, hygiene, dressing and toilet use. He required supervision for mobility and eating. The resident was coded for having adequate vision without glasses. The resident was coded for not exhibiting verbal behaviors directed towards others. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	D. Observation On 8/11/21 at 9:00 a.m.,the resident was observed to be sitting in his doorway. Resident #1's room is directly across from Resident #36's room. On 8/11/21 at 9:33 a.m., the resident was observed to be walking with restorative certified nurse aide (RCNA) #2 down the hall. Resident #1 said to the RCNA #2 that he just saw that N word down the hall by his room. RCNA #2 did not address what Resident #1 said and continued to encourage him to focus on his walking. E. Record review Resident #36's electronic medical record failed to show any evidence that the facility reacted and handled this situation accordingly. F. Interview The RCNA #2 was interviewed on 8/17/21 at 11:28 a.m. The RCNA #2 said she had heard Resident #1 say the ' N word on 8/11/21 while he was walking in the morning. She said she would try to encourage him to talk about something else, but did not address what he was saying. She said Resident #1 said that word often and had heard him say it more than once. She said Resident #1 has talked about his wife having an affair with an African American man and that was why she believed he said that word when he saw the two African American residents who live across the hall from him. She said Resident #1 was roommates with an African American resident and the facility moved him across the hall when they identified he was calling his roommate the N word. She said she thought moving Resident #1 to a different hall would make a difference because he would not see the African American resident every day and having him live across the hall from him gives him more opportunity to say that word. Certified nurse aide (CNA) #3 was interviewed on 8/17/21 at a.m. The CNA confirmed Resident #1 called both Resident #36 and another resident the derogatory name (N word). The CNA said she had reported it to the administration, however, nothing had come of it. She said that she knew it bothered the gentlemen it was said to. CNA #3 said the resident had an experience in his past life with his wife having an extra marital affair with an African American man. She said that did not justify the reason to call the residents the derogatory name. The social worker (SW) was interviewed on 8/17/21 at 3:33 p.m. The SW said he was aware that Resident #1 used the N word toward Resident #36. The SW said that he has heard Resident #1 use the N word toward Resident #36. He said he had explained why it was inappropriate to use the word, however, he hoped it stuck. He said each time it was used a grievance form should be filled out. However, the SW said there have been no grievances filled out. 44997 VI. Knock on door A. Resident status (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #2, age 62, was admitted [DATE]. According to the August 2021 CPO diagnoses included, unspecified fracture of shaft of left tibia (shin bone), hypertension, and chronic viral hepatitis. The 5/5/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required supervision with personal hygiene. B. Resident interview Resident #2 was interviewed on 8/12/21 at 9:52 a.m. The resident said that he did not like when staff entered his room without knocking. He said they just rush in without knocking. He said he had complained but had not had any resolution. C. Observations The resident's door had a sign on it to knock before entering. On 8/11/21 at 11:00 a.m.,the certified nurse aide (CNA) #5 taking orders for the meal was observed to go in and out of resident doors without knocking. On 8/12/21 at approximately 2:00 p.m., licensed practical nurse (LPN) #2 was observed to enter a room without knocking. On 8/16/21 at approximately 10:00 a.m., an unidentified housekeeper walked into Resident #2's room without knocking. D. Record review The grievance form was completed on 6/1/21 which documented LPN #5 entered the residents room without knocking. The grievance documented they (staff) walk right in, regardless if the door is open or shut. E. Interview The DON was interviewed on 8/18/21 at 11:55 a.m. The DON said she received the grievance and educated the LPN to be supportive to the resident and to knock before entering the room. She said she would provide education.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on interviews and record review the facility failed to ensure three (#50, #2 and #36) of four out of 32 sample residents reviewed had the right to participate in the development and implementation of their person-centered plan of care. Specifically, the facility failed to invite schedule a care conference with the Resident #50, #2 and #36. Findings include: I. Facility policy The care plan development and communication policy was provided by the regional nurse consultant on 8/17/21 at 3:00 p.m. It read, in pertinent part: The resident and/or responsible parties are invited in writing to the residents ' care plan meeting. Each resident and/or responsible party are invited and included at the specific time for the care conference. If the time is inconvenient for the resident and/or family member, a separate meeting is rescheduled to accommodate their needs. II. Residents not attending care conferences 1. Resident #50 A. Resident #50 status Resident #50, age 41, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis, depression, anxiety, and chronic pain. The 4/14/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status assessment score of 15 out of 15. The resident required extensive assistance for activities of daily living. The resident had no behaviors impacting care. B. Interviews Resident #50 was interviewed on 8/11/21 at 2:32 p.m. She said she was not involved in care planning. She said she was informed of the care conference meeting but that staff did not come to get her for the meeting. She said she was unable to ambulate herself or self propel herself to the meeting. C. Record review Progress notes indicated the last documented care conference meeting in the electronic medical record was 1/19/21. It did not list Resident #50 in attendance, invited or if the resident declined attending. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20287 2. Resident #36 A. Resident status Resident #36, age 91, was admitted on [DATE]. According to the August 2021 CPO diagnoses included, malignant neoplasm (cancer) of colon, and multi system degeneration of the autonomic nervous system. The 6/15/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. The resident was independent in all self care areas. The resident had no behavior issues. B. Resident interview Resident #36 was interviewed on 8/11/21 at 10:47 a.m. The resident said he did not attend the care conference meetings. He said that he did not recall the last time he was invited. He said he had attended one in the past, and only the activity director was at the meeting. C. Record review Progress notes indicated the last documented care conference meeting in the electronic medical record was 6/22/21. It did not list Resident #36 in attendance, invited or if the resident declined to attend. 3. Resident #2 A. Resident status Resident #2, age 62, was admitted [DATE]. According to the August 2021 CPO diagnoses included, unspecified fracture of shaft of left tibia (shin bone), hypertension, and chronic viral hepatitis. The 5/5/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental statu score of 15 out of 15. The resident required supervision with personal hygiene. B. Resident interview Resident #2 was interviewed on 8/11/21 at 9:53 a.m. The resident said he had not been invited to his care conference. He said he would like to be involved with his plan of care. C. Record review Progress notes indicated the last documented care conference meeting in the electronic medical record was 2/16/21. It did not list Resident #2 in attendance, invited or if the resident declined attending. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Staff interview The social worker (SW) was interviewed on 8/17/21 at 3:30 p.m. The SW said there were not sign in sheets at care conferences but those (staff, residents, family members) in attendance were included in the progress note. He said some residents may decline attending the care conference and that he should document that the resident was invited and declined. He said he was not documenting this currently.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 44997 Based on observations and interviews, the facility failed to ensure residents received notices orally and in writing which included a written description of their legal rights. Specifically, the facility failed to have the required posted information written in a readable font size and placed in an area that had ease of access for the residents. Findings include: A. Resident interviews An individual resident council interview with two out of three residents selected by the facility was completed on 8/17/21 at 2:30 p.m. Resident #18 said she was unsure where to locate the information in the facility on how to file a complaint with the state. She said that she would have to ask a staff member to help her locate the phone number if needed or use her personal cell phone to search for the information herself. Resident #34 said she was unaware of how to file a complaint with the state. She was not aware where the information was posted. B. Observation Postings were located in one location at the front of the building across from the administration offices. The postings were located on a bulletin board next to the administration conference room. The postings were behind closed doors from the rest of the building where the residents reside. The doors were closed with a sign stating residents were not allowed to pass through the doors. The State Health Department's email address was not included in the posting. C. Staff interviews The social services assistant (SSA) was interviewed on 8/17/21 at 3:32 p.m. He said he was not sure which department was responsible for the facility postings including Adult Protective Services phone number, State Health Department phone number, ombudsman phone number, and medicare fraud phone number. The SSA said he knows they are posted in the front of the building but he is not the one who put them there. The activity director (AD) was interviewed on 8/17/21 at 4:46 p.m. He said he did know the required notifications and contact information for residents was posted in the front of the building but he does not know who is responsible for posting the information. The nursing home administer (NHA) was interviewed on 8/18/21 at 7:00 p.m. The NHA said she was not aware all the contact information was not posted, and she was not aware residents were unsure of how to file a complaint with the state. 20287

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F 0584

Level of Harm - Potential for minimal harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43134

Based on observations, record review and interviews, the facility failed to provide a safe, sanitary, and comfortable homelike environment for one resident (#44) out of 32 total residents.

Specifically the facility failed to:

-Ensure Resident #44's bathroom was sanitary and safe for the resident to use

Findings include:

A Observations

On 8/11/21 at 9:12 a.m., Resident #44 bathroom had a black substance on the base of the walls where it met the floor. The baseboards were stripped away from about 75 percent of the walls and had a black substance on one side of them. There were several wipes with the black substance in a pile with the baseboards. The floor had a black substance around the back and sides. The toilet bowl had concentrated urine with toilet paper with some black substance in it The bathroom had a foul smell of mold and urine. Resident #44 resided in the room and was unable to use the toilet because of the bathroom conditions.

-At 10:25 a.m. the two staff members moved Resident #44 with her packed belongings and moved her to another room. The staff member said the NHA instructed them the resident needed to be moved to a different room because of the conditon of the bathroom.

B. Interviews

Registered nurse (RN) #2 was interviewed on 8/11/21 at 9:20 a.m. He said the bathroom was not used for the last month, he had reported it to maintenance assistant (MA) #1 and the nursing home administrator (NHA).

Certified nurse aide (CNA) #1 was interviewed on 8/11/21 at 11:51 a.m. She wrote a work order for the bathroom in 328 and placed it in the maintenance request book. However when she looked in the maintenance request book, she did not see the form she filled out and the other forms for the last week had been removed from the request book.

The housekeeping supervisor (HSKS) was interviewed on 8/11/21 at 11:59 a.m. She said she was hired as the housekeeping supervisor about a month and half prior and the bathroom in resident room [ROOM NUMBER] was in the same condition as it was when she first began to work at the facility. She said she notified maintenance and asked her not to clean the resident room [ROOM NUMBER]. When Resident #44 asked to use the restroom, the staff brought her to the staff restroom next to the nurse's station and was incontinent at times.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	The NHA was interviewed on 8/11/21 at 11:00 a.m. She said the interdisciplinary team had a meeting about Resident #44 increased behaviors that caused the resident to pick at the walls in her room and bathroom. The resident moved from her room [ROOM NUMBER] to #318 because the bathroom needed extensive repairs. MA #1 was interviewed on 8/11/21 at 1:00 p.m. He said he used the maintenance book to know what repairs were needed in the building. The maintenance book was located at the nurses stations and the requests were removed from the book every week and when the work order was completed. He did not have requests for Resident #44's bathroom. in the last month. He said he asked the staff to leave the written requests in the books at the nurse station so that he would remember what they asked him for. He would work on the order when he would be able to and write on the work order when it was completed and place it in the completed orders. The maintenance director (MD) was interviewed on 8/18/21 at 5:15 p.m. He said the maintenance department had a request book at each nurses station and retrieved the forms every morning. The completion of the requests depended on the urgency of the request, the time to complete them and if parts needed to be ordered and would be completed as soon as possible. There was not a process for completed work orders to ensure they were finished.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44997 Based on interviews and record review, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances for all residents. The facility failed to develop and maintain a grievance process that ensured the residents received appropriate resolution to their identified concerns. Specifically, the facility failed to ensure residents' grievances and concerns were reported, tracked, investigated and enacted a plan for resolution. Findings include: I. Facility policy The Complaints and Grievances policy, last revised September 2019, was provided by the regional nurse consultant (RNC) on 8/17/21 at 5:00 p.m. The policy revealed in pertinent part, In a healthcare community, in most instances, the Complaint/Grievance Officer is the Social services director or other appropriate designee. The Complaint/grievance officer provides oversight of the grievance process, including: -Receiving and tracking grievances through their conclusions; -staying in periodic contact with the person who filed the grievance until the matter is investigated, and a plan is enacted for resolution; -Coordinating the issuance of any necessary written response, at the direction of the Administrator, to the person who initiated the grievance and coordinating with state and federal agencies as needed; -The resident is advised to complete all sections of the complaint/grievance form as accurately as possible. Staff members of the community may assist the resident, family member, or representative with the completion of theth form; -The staff member who receives the completed complaint/grievance report form submits it to the designated complaint/grievance office or designee by the end of their shift; -The complaint/grievance officer, in consultation with the administrator, develops a process/plan for resolution of the grievance and notifies the complainant about the plan for resolution; and -A grievance is considered resolved when the resident or grievant is satisfied with the actions taken on his/her behalf. II. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The review of the Resident Council minutes from March 2021 through August 2021 revealed numerous resident concerns: -Residents requested ancillary services such as dental and eye care; -difficult to make an appointment with social services and needs not being met; -staff enter rooms without knocking; -staff walk by room without answering call lights; -lack of nurse staffing; -staff turnover and use of agency; -Activities only offered on tv; -Residents requested having games left out in the evening; Review of the concerns/grievance log for the facility failed to identify any of the concerns identified during the last six months of resident council minutes provided by the facility. III. Staff interviews The social worker (SW) was interviewed on 8/17/21 at 3:32 p.m. He said he was the one who manages the concern/grievance binder. He said anyone can fill out a grievance form and leave it in his mailbox. He said when he received a grievance form for a specific department he would give it to the department manager to follow up with the resident. Once the grievance was addressed the department manager will give the completed form to the nursing home administrator and he will put the completed form in the binder. The SW said he did not fill out any grievance forms from resident council and assumed the life enrichment director (LED) filld out the forms and delivers them to the appropriate department manager. The SW reviewed the last six months of resident council minutes and said he was unaware of the ancillary concerns noted in the minutes. He reviewed the grievance binder and was unable to find grievance forms addressing the concerns noted in the resident council minutes for the past six months. The Regional nurse consultant (RNC) was interviewed on 8/17/21 at 4:00 p.m. She reviewed the grievance binder and was not able to find completed grievance forms for the specific concerns identified during the resident council minutes. She said since the social services director resigned things have fallen through the cracks. She said she can tell us how the grievance process should be handled but can not say it was being done correctly currently in this facility. She said they have brought in a consultant to help the social services department and the consultant has also identified the grievance process as a concern. The RNC said she will help the SW with the follow-up and concerns identified with the department overall. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The (LED) was interviewed on 8/17/21 at 4:46 p.m. He said that he is responsible for running the resident council meetings and writing up the minutes for each meeting. He said each department manager is invited and attends the meetings when possible. He said he provided the meeting minutes to the NHA and the department managers and assumed each manager would follow up with their department concerns. He said he did not fill out grievance forms from the meetings and assumed the managers would read the minutes and provide their own follow up specific to each department. He said he does fill out grievance forms for his own department.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 20287 Based on interview and record review the facility failed to report an alleged violation of abuse to the State survey and certification agency in accordance with State law for one resident (#2) out of three residents reviewed for abuse out of 32 sample residents. Findings include: I. Facility policy The Abuse policy, dated 3/13/13, was received on 8/18/21 by a regional nurse consultant. The policy read in pertinent parts, the following qualify for reportable incidents, allegations of abuse or neglect, which includes physical, verbal and neglect. II. Failure to report alleged violations of abuse to the State Survey and Certification Agency involving Resident #2. (Cross-reference F610) The Grievance Form for Resident #2, dated 6/1/21, was provided by the social service director (SSD) on 8/11/21 at approximately 2:00 p.m. The grievance form revealed it was reported to the social service director on 6/1/21, documented, Resident #2 said a licensed nurse shook his fists at me. The form documented this had been going on for a while. The documentation of follow-up revealed the director of nursing interviewed the resident and the LPN on 6/2/21. -However, the facility did not investigate the allegation of abuse (F610) nor reported it to the State Agency until identified during the survey. III. Interviews The NHA was interviewed on 6/18/21 at 7:22 p.m. The NHA said she coordinated the investigations into abuse. She said as the coordinator she needed to be informed immediately. She said her phone number and email were posted throughout the building, and all staff were aware of the process. She said she was not notified of this abuse allegation when it was received. She said investigations were done by interviewing the persons involved. Abuse reports were made to the State Agency, police, family, medical director. She confirmed this abuse allegation was not reported to the State Agency, however, she had since reported it to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on interviews and record review, the facility failed to timely and thoroughly investigate an alleged violation of physical abuse for one (#2) of two allegations reviewed out of 32 sample residents. Specifically, the facility failed to timely and thoroughly investigate an allegation of physical abuse reported by Resident #2. Findings include: I. Facility policy and procedure The Abuse policy, dated 3/13/13, was received on 8/18/21 by a regional nurse consultant. The policy read in pertinent part, An investigation is a formal and systematic collection and review of available evidence and factual information that seeks to describe or explain an event or series of events. The goal of every investigation are to: (1) Obtain as much factual information as possible in an effort to reconstruct and evaluate an incident, event or circumstance; (2) provide the possible, as to how and why an incident occured or whether an allegatio can or cannot be substantiated; (3) determine what remedial and/or corrective action , if any, may be appropriate to protect residents, prevent recurrence and improve quality of care; and (4) determine whether the incident must be reported to any regulatory body, governmental agency and/or licensing/accreditation organization. The following require prompt investigation and should be immediately reported to the Executive Director/Administratiro: allegations of resident abuse or neglect, which includes physical, verbal, psychological, sexual, involuntary seclusion or misappropriation of resident property or finances (Abuse), whether made by the resident, an employee, a family member/responsible party or visitor and whether made verbally or in writing. II. Resident status Resident #2, age 62, was admitted [DATE]. According to the August 2021 CPO diagnoses included, unspecified fracture of shaft of left tibia, hypertension, and chronic viral hepatitis. The 5/5/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental statu score of 15 out of 15. The resident required supervision with personal hygiene. III. Resident interview Resident #2 was interviewed on 8/11/21 at 9:53 a.m. The resident said he reported to the social worker (SW) a few months ago, that licensed practical nurse (LPN) #5 shook his fists in his face. He said that he had a grievance filled out, as this was not the first time he had words with this particular LPN. He said he had not heard of any outcome of the abuse allegation. IV. Record review (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The abuse allegation was filed under a grievance form and was filled out on 6/1/21 at 1:28 p.m. The form was signed by the SW. The grievance report documented Resident #2 reported LPN #5 shook his fists at me. The grievance outcome was dated 6/2/21 at 9:00 a.m. The summary documented the resident was interviewed and said the shaking of the fist only occurred once. The DON spoke with the LPN #5 and educated the LPN that the resident had a traumatic brain injury and may be experiencing a difficult reality and he needed to be supportive and gentle with the resident. -The grievance form documented the roommate and LPN #5 were interviewed, however, the investigation failed to show documentation of the actual interview. The investigation failed to show other residents, and staff members working were interviewed. The investigation was not completed timely as it was not addressed until the following day. -The facility did not report the allegation resident made against LPN #5 to the State Agency (cross-reference F609 for timely reporting of an abuse allegation). V. Interviews The SW was interviewed on 8/11/21 at approximately 1:00 p.m. The SW said that he did have a grievance on this situation, however, he turned it over to the director of nursing (DON). He was not aware of the outcome. The DON was interviewed on 8/18/21 at 11:55 a.m. The DON said she received the abuse allegation the following day. She said she interviewed the resident and he said the resident did not want the trash emptied, and that LPN shook his fist in his face. The LPN was interviewed and denied the allegation. The DON said the LPN had raised his arms while talking but was not doing it in a threatening manner. She said that she educated the LPN to be more supportive to the resident related to his traumatic brain disorder. The DON denied talking to other residents and to other staff members. She said the resident felt safe at the facility. The NHA was interviewed on 6/18/21 at 7:22 p.m. The NHA said she coordinated the investigations into abuse. She said as the coordinator she needed to be informed immediately. She said her phone number and email were posted throughout the building, and all staff were aware of the process. She said she was not notified of this abuse allegation when it was received. She said investigations were done by interviewing the persons involved and were to be completed immediately. She confirmed the investigation did not include other staff members or residents and was not completed timely.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43134 Based on observations, interviews and record review, the facility failed to provide the necessary assistance with activities of daily living (ADL) for five (#65, #50, #37, #20, #34) of eight residents reviewed for activities of daily living out of 32 sample residents. Specifically, the facility failed to provide bathing according to the resident's preferences for Resident #65, #50, #37, #20 and #34. Cross-reference F725 for sufficient staffing. Findings include: 1. Resident #65 A. Resident status Resident #65, age 66, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included Parkinson's disease, peripheral vascular disease, dementia, muscle weakness and hypothyroidism. The 7/28/21 quarterly minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) unknown out of 15 because resident was rarely or never understood. He required two or more persons total assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. He required total dependence on one staff member for eating, he was not able to walk and required total assistance for bathing. B. Observations On 8/11/21 at 10:10 a.m. Resident #65 laid in his bed with his knees bent to the right and faced the wall and could move his head facing forward. His hair had a dull and greasy appearance and had knots through his hair. He had a dry flaky appearance to his scalp and his fingernails were long and had a black and brown substance to most of them. His voice was garbled and unclear. C. Record review The care plan last update on 4/28/21 read Resident #65 was at risk for increased limitation in his ability to perform activities of daily living (ADL)s independently due to his diagnosis of Parkinson's disease, some memory loss, mobility limitations and weakness. The interventions related to this area included to check nail length and clean on his scheduled bath days as necessary, shower or bed bath twice weekly with extensive assistance by staff on Mondays and Thursdays. The shower task for Resident #65 revealed that he did not receive a shower, bathing or bed bath from 6/29/21 until 7/16/21, or 18 days. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #37 A. Resident status Resident #37, age 84, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paraplegia with post-polio syndrome, dementia with behavioral disturbances, scoliosis, depression, acute conjunctivitis, a history of fractured hip and weakness. The 6/16/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) of three out of 15. She required total dependence with two or more people for assistance with transfers and bathing extensive assistance with two or more people with bed mobility, toilet use and dressing. Extensive assistance with one person assist with personal hygiene and supervision with set up help for eating. B. Observations On 8/12/21 at 10:45 a.m. Resident #37 rolled through the hallway to her room in her electric wheelchair. She had long jagged fingernails, and a black substance underneath her nails. Her hair looked greasy and dull. C. Resident interview Resident #37 was interviewed on 8/12/21 at 10:45 a.m. She said it had been awhile since the last time she had a shower. She felt like she did not get showers as often as she preferred and did not know who would listen to her. D. Record review The care plan last revised on 7/19/21 read the resident had limitations to complete her activities of daily living (ADL)'s because she had left sided weakness due to post-polio syndrome, general weakness and scoliosis. She required extensive to total assistance with bathing and preferred to receive a bath or shower once or twice every two weeks. Fingernails were needed to be trimmed and cleaned on bath days. Resident #37 shower records read she received one shower on 8/15/21 in the past 30 days from 8/18/21. E. Staff interviews The director of nursing (DON) was interviewed on 8/17/21 at 5:00 p.m. She said residents received their showers according to their preferences and their care plan. They are documented under the tasks in the electronic charting system. 44949 3. Resident #50 A. Resident #50 status (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50, age 41, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPOs), diagnoses included hemiplegia and hemiparesis, depression, and chronic pain. The 4/14/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status assessment score of 15 out of 15. The resident required maximal assistance for activities of daily living including bathing. The resident had no behaviors impacting care. B. Observations and resident interview On 8/11/21 at 2:50 p.m. Resident #50 was observed in her room. The resident had returned from the smoking area outside and was upright in her wheelchair. Her hair appeared greasy and unkempt. On 8/17/21 at 2:20 p.m. Resident #50 was observed in her room. Her hair continued to appear greasy and matted in the back. She said she was offered a shower during the previous evening but did not want a full shower because the water is not hot. She said she was not offered an alternative. She said her hair was sensitive but she wanted to have it washed. She said later in the evening she asked if she could have her hair washed but a staff member told her it was too late. C. Staff interview Licenced practical nurse (LPN) #1 was interviewed on 8/18/21 at 11:37 p.m. She said Resident #50 refuses showers frequently. She said Resident #50 will request a bed bath ten minutes before shift change and is told she will need to wait. She said Resident #50 will then get upset because she has to wait and then will refuse the bed bath. She said Resident #50 would not allow staff to brush her hair. She said they have suggested the resident cut her hair but the hairstylist is not currently coming into the facility. D. Record review The activities of daily living care plan was revised on 8/4/21. It indicated the resident had a preference for showers to be provided in the evenings twice a week with extensive assistance. The July and August 2021 documentation report indicated the resident received no showers for either month with entries marked as resident refused. The medical record failed to show any evidence that the resident was provided any education or intervention when she refused her shower. 20287 4. Resident #20 Resident #20, age 87, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO) diagnoses included diabetes, unspecified dementia without behavioral difficulties,and dysphagia. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/1/21 minimum data set (MDS) assessment showed the resident had minimal cognitive impairment with a score of 11 out of 15 for the brief interview for mental status (BIMS). The resident required extensive assistance from one for bathing. Resident interview The resident was interviewed on 8/11/21 at 2:14 p.m. The resident said she did not receive her showers twice a week as scheduled, due to lack of staff (cross-reference F725 sufficient staffing) and at times not enough hot water. The resident said she wanted a shower three times a week. Record review The care plan dated 1/25/21 identified the resident had limited ability to perform activities of daily living. Pertinent interventions were to assist with showers three times a week. The resident required extensive assistance with showers. Review of the August 2021 showed the resident was to receive a bath three times a week. -From 8/1/21 to 8/18/21 the resident received three shower out of eight opportunities 5. Resident #34 Resident #34, age 92, was admitted on [DATE]. According to the August 2021 CPO diagnosis included, bilateral muscle weakness, overactive bladder and hypertension. The 6/16/21 minimum data set (MDS) assessment showed the resident had minimal cognitive impairment with a score of 11 out of 15 for the brief interview for mental status (BIMS). The resident required supervision from one for bathing. Resident interview Resident #34 was interviewed on 8/17/21 at p.m. The resident said she did not receive her showers twice a week like she had been promised. She said the showers were not given because of short staff (cross-reference F725). Record review The care plan dated 1/25/21 identified the resident had limited ability to perform activities of daily living related to mobility limitations, and weakness. Pertinent interventions were to use short instructions such as hold your washcloth in your hand to promote independence, shower or tub bath once or twice a week. -Review of the July 2021 activities of daily living documentation showed the resident received five showers out of nine opportunities. Review of the August 2021 showed the resident was to receive a bath on Monday and Thursdays and as needed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-From 8/1/21 to 8/18/21 the resident received one shower out of five opportunities Interviews Certified nurse aide (CNA) #3 was interviewed on 8/17/21 at approximately 2:00 p.m. The CNA said showers were often skipped as there was not enough staff (F725). She said the residents could receive as many showers as they preferred, but were to receive at least two a week. The director of nursing was interviewed on 818/21 at approximately 5:00 p.m. The DON said she was aware that showers were skipped when the staffing was low. However, the showers were to be made up the next day. The DON said they used restorative CNAs to help make up showers.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on observations, record review and staff interviews, the facility failed to provide an ongoing program to support residents in their choice activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two (#12 and #22) of three out of 32 sampled residents. Specifically, the facility failed to offer and provide personalized activity programs for Resident #12 and #22 as documented in the care plan. Findings include: I. Facility policy and procedure The Activity policy, initiated on 9/1/14, was provided by the nursing home administrator (NHA) on 8/24/21 at 9:00 a.m. It documented in pertinent partthe community will provide space, supplies, equipment and the staff support necessary for social physical, educational and leisurely activities, both within and outside the community, that are planned according to the preferences, needs and abilities of residents. The community will encourage participation in independent or self-directed activities as well as offer group activities at least three times a week. II. Resident #12 A. Resident status Resident #12, age 78, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included legal blindness and difficulty walking. The 5/12/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental (BIM) status score of nine out of 15. He required extensive assistance with transfer and total dependence with bed mobility. B. Observations and interview On 8/11/21, at 9:56 a.m. the resident was lying in bed. There was a radio in his room by the window. It was not turned on. The resident was lying on his back looking towards the ceiling. The television (TV) was on. The resident said he likes to listen to music (Spanish). He said he was blind and could not watch TV. He said the staff was supposed to turn his radio on and play his favorite Spanish music. He said no one came into his room to turn his radio on. He said he was bored. On 8/12/21 from 2:00 p.m. to 3:30 p.m., the resident was observed lying on his back in his room looking up to the ceiling without stimulation. The radio was observed in the room but was not turned on. Multiple staff walked by and no one offered to turn his radio on to listen to his favorite music. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/17/21 from 10:00 a.m. to 11:15 a.m. the resident was lying in his bed looking up to the ceiling without stimulation. Observed a radio in the room but it was not turned on. Observed activity staff on unit but they did not go into the resident's room to offer to turn his radio on to listen to his favorite music as documented in his plan of care. C. Record review The 2/9/21 MDS assessment, Section F (Interview for Activity Preferences) revealed it was very important to listen to music he likes, do favorite activities and participate in religious services. The comprehensive care plan initiated on 2/16/21 and revised on 8/3/21 identified the resident had little or no programing involvement related to physical limitations. Interventions included for activity staff to provide a radio in the resident's room. It documented the resident was happy when he heard Spanish language and music, the resident was able to listen to television and listen to the radio. The resident needs assistance/escort to programs. The August 2021 activity participation log was reviewed. It revealed multiple activities codes which identified the type of activity. It documented the following activities: 8/11/21-codes 36-resting, 30-social visits and 28-socializing with others. 8/12/21-codes 28 and 36. 8/17/21-codes 30, 28 and 31-food social. -Activity code 6 identified the type of activity as music/sing/play. However, the log did not document that the resident participated in his favorite activity as documented in his care plan. -There was no documentation of times and duration of the activities. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/18/21 at 11:10 a.m. She said the resident had a radio in his room and he liked to listen to Spanish music. She said the activity staff was responsible for turning his radio on. She said he stayed in bed most of the time and he enjoyed listening to his music. She said sometimes when she was working with the resident, she would turn his radio on but not all the time. The life enrichment director (LED) was interviewed on 1/18/21 at 12:30 p.m. He said Resident #12 liked to listen to his favorite music. He said a radio was in the resident room for him to listen to his music. He said a couple of days ago, he turned the resident's favorite music on. He said the resident was happy when he heard his favorite music playing. He said the activity staff should have offered to turn the resident's radio on and play his favorite music. He said he was not aware that the resident's radio was not turned on in his room. He said he would educate the activity staff to offer the resident a chance to listen to the music of his choice. 44997 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #22 A. Resident status Resident #22, age 57, was initially admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included nontraumatic subarachnoid hemorrhage from unspecified intracranial artery, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, aphasia (loss of ability to understand or express speech) dysphagia (difficulty swallowing) and abnormal weight loss. The 6/1/21 annual minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS.) The assessment documented she was moderately cognitively impaired for daily decisions Resident #22 required extensive two-person assistance with transfers, and extensive one person assistance with bed mobility, dressing, hygiene eating, and toileting. She had a feeding tube. -The preferences for the customary routine and activities section of the annual MDS was not completed. B. Observations On 8/11/21 at 9:22 a.m. a continuous observation was conducted and completed at 12:45 p.m. Resident #22 was observed lying in bed holding a hairbrush in her left hand. The television (TV) was on in her room. At 9:58 a.m. the life enrichment assistant (LEA) #2 was pushing an activity cart down the hall. LEA #2 was observed entering other resident rooms, but did not enter Resident #22's room. At 10:53 a.m. LEA #1 entered Resident #22's room to visit with her roommate. LEA #1 visited with the roommate for approximately 30 minutes, but did not engage or visit with Resident #22. At 12:45 p.m. the continuous observation ended and noted that no activity staff were observed interacting with Resident #22 or offering her social visits or activities of interest. At 1:55 p.m a continuous observation was conducted and completed at 4:00 p.m. Resident #22 was observed lying in bed with nothing in her hand. The television was on in her room. At 2:10 p.m. LEA #2 notified residents of a [NAME] movie on TV, but did not observe LEA #2 enter Resident #22's room. At 2:52 pm LEA #1 entered Resident #22's room to visit with her roommate. LEA #1 did not interact or visit with Resident #22. At 3:21 p.m. Resident #22 was lying in her bed holding a [NAME] Mouse doll. She had her TV channel on the facility's channel 37 which plays the movies and shows the activity department plays to match up with the activity calendar. She had the [NAME] movie on her TV but was not watching the movie. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 4:00 p.m. the continuous observation ended and noted that no activity staff were observed interacting with Resident #22 or offering her social visits or activities of interest. C. Record review The Life 360 Admission Evaluation on 6/3/21 identified Resident #22 had a cognitive deficit, communication deficit, and needed assistance from staff for activity participation. The evaluation identified one-to-one visits from staff, hand massage, stuffed animals and spanish music as interventions and preferences for Resident #22. Review of Resident #22's activity care plan, initiated on 6/17/20 and revised on 7/19/21 revealed the resident was dependent on others for daily leisure needs. The care plan documented the resident enjoyed Spanish music, staff one-to-one social visits, hand massage with lotion, holding her stuffed animal and the rosary. -Since the resident was admitted on [DATE], there was a total of seven activity progress notes and one activity assessment completed. The life enrichment director (LED) provided Resident #22's August 2021 daily activity participation record on 8/18/21 at 1:00 p.m. The record revealed the resident participated in two to four activities a day on average. -The documentation did not provide the time of the activity or the staff person documenting the activity. The record did identify the activity and if the resident was available to participate. Numerous activities were documented reflecting that Resident #22 was not available to participate. -However, the resident was dependent on staff for participation and is bed bound. -In particular, on 8/11/21 the resident's participation record revealed that the resident participated in five activities and was unavailable for two activities, but the resident was observed to be in her bed without being offered activities (see above). D. Staff interview The LED was interviewed on 8/17/21 at 4:46 p.m. and again on 8/18/21 at 12:37 p.m. The LED had been at the facility as the LED for one year and was an activity assistant since 2009. He said he had two assistants who work a staggered schedule to cover the activity department seven days a week. He said he conducted the initial, annual and change of condition assessments on point click care (PCC) and had a paper log of the resident's daily participation in a binder. He said not all of the activity assistants were comfortable using PCC so they were doing the daily documentation on paper. The LED was responsible for the resident assessments and all of the activity staff were responsible for the daily documentation. He said he updates the care plans in PCC but does not document quarterly progress notes for the care plans and said the social worker runs the care conferences and assumed he wrote a quarterly note. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LED provided the daily participation record for Resident #22 and reviewed her participation. He said she receives most of her activities in her room in her bed. He said she enjoys watching TV and holding her stuffed animals. He said he has tried to set up Zoom meetings with her family but he cannot force the family to participate. He said he provides social visits and turns on music for her in her room. He said it would be important to know who was providing the activity and the time the activity was conducted to be reflected in the daily documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview, and record review, the facility failed to ensure five (#18, #50, #35, #37, and #56) of five out of 32 sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered plan. Specifically, the facility failed to: -Follow physician orders for medication administration for Resident #18, #50, and #1; -Ensure glucometer audits were completed to maintain accuracy for Resident #56; -Notify nurse regarding a change in condition for Resident #37 observed by two other staff members; and, -Provided needed resources to prevent a decline for Resident #35. Finding include: I. Need resources to prevent decline Resident #35 A. Resident status: Resident #35, age 68, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, hypertension, heart failure, peripheral vascular disease and obesity. The 6/16/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He required total dependence with two or more persons to assist with transfers, total extensive assistance with two or more persons to assist with bed mobility, dressing and toilet use, supervision with one person assistance to eat. He did not walk during the look back period for this MDS assessment. He was six feet tall and weighed 440 pounds B. Resident interview Resident #35 was interviewed on 8/12/21 at 10:15 a.m. He stated he wanted to get out of bed and sit in his wheelchair. He said he required maximum assistance with a mechanical lift to transfer out of bed. The resident said when he was transferred in the mechanical lift he had a lot of pain that he explained as a constant and unbearable pain in his legs felt squeezed and was scared when he was in the sling because he could not breathe. C. Record review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the weights documented in the electronic medical record (EMR), Resident #35 had a weight gain difference from 336 pounds on 6/10/20 to 464 pounds on 4/21/21. The care plan last revised on 7/19/21 read, Resident #35 required maximum assistance and a mechanical lift for all transfers. Resident #35 had an increased risk for pain and would verbalize pain relief or incomplete pain relief. Staff interventions were to observe and report any changes to his usual routines, a decline in ADLs or resistive care. The admission 6/18/2020 MDS assessment read the resident was a maximum assist with two or more staff assistance for transfers, supervision with setup help only, he used a walker The 6/16/21 MDS assessment read the resident declined in transfers to total dependence on two or more staff assistance for transfers, supervision with one person physical assistance and did not use a walker. A progress note on 7/22/21 at 3:45 a.m. read the resident refused his shower because the mechanical lift hurt his legs. The physical therapy note on 5/30/21 read the resident was measured for an appropriate size wheelchair and for a bariatric sling. The note further documented, the specialty sling was not not available at the facility The resident physical therapy screening form dated 8/12/21 read, Resident #35 was recommended to physical therapy for an evaluation due to the mechanical lift sling caused was painful when he needed to transfer out of bed for showers or to be weighed. A bariatric sling was ordered by the business office. D. Staff interviews The director of nursing (DON) was interviewed on 8/18/21 at 4:00 p.m. The DON said she was aware the resident had not been getting out of bed as the facility did not have a bariatric sling. She said he needed a specialty sling as the current one, hurt him. She said the therapy department had been following the resident to assist with a better fitted sling, however, the specialized sling was not received as of yet. The director of rehabilitation (DOR) was interviewed on 8/19/21 at 2:32 p.m. The DOR said the resident had a large weight gain and had difficulty when he used the mechanical lift because the sling used with the mechanical lift caused him pain. The therapy department made modifications to the mechanical lift sling with additional towels or pillows for more cushion. He was discharged from therapy in November of 2020 and was not seen by therapy again until 5/30/21. E. Record review Resident #35 was evaluated by therapy on 5/30/21 because he had a decline in activities of daily living (ADL) and participation. Physical therapy took measurements of the resident for a new bariatric sling for the mechanical lift and bariatric chair. However, it was ordered by the business office on 8/12/21 as a request from the therapy department. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35 requested to wait on more therapy until he received a mechanical lift that accommodated him without pain. The equipment the resident needed to improve or maintain Resident #35's ADLs were not available until it was ordered three months after the measurements were taken by the physical therapist. II. Notification of change of conditon 1. Resident #37 A. Resident status: Resident #37, age 84, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paraplegia with post-polio syndrome, dementia with behavioral disturbances, scoliosis, depression, bilateral conjunctivitis, a history of fractured hip and weakness. The 6/16/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score (BIMS) of three out of 15. She required total dependence with two or more people for assistance with transfers and bathing extensive assistance with two or more people with bed mobility, toilet use and dressing. Extensive assistance with one person assistance with personal hygiene and supervision with set up help for eating. B. Observations On 8/16/21 at 11:20 a.m. Resident #37 said she felt like something was in her left eye and it was hurting. She had long fingernails with a black substance under them and used her fingernail to scratch the inside of her lower eyelid. At approximately 11:30 a.m., the resident's eye became more reddened and swollen and she said it was bothering her a lot. -At 11:45 a.m. the social worker (SW) leaned down to listen to her. The SW told the resident he would notify the licensed nurse that her eye was needing to be assessed. -At 12:10 p.m. the resident spoke with the life enrichment director (LED) and informed him her eye was hurting. The LED said he would tell her nurse. -At 12:10 p.m., certified nurse assistant(CNA) #5 asked resident #37 if she wanted her lunch in her room and the resident told her she was not feeling well. The resident was observed to notify three staff members to have the nurse come and assess her eye, however they failed to notify the nurse. C. Record review An order was initiated on 8/17/21 at 8:30 p.m. for artificial tear ointment to be applied to the resident's eyes at bedtime. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/17/21 provider progress note stated the resident had drainage, erythema (redness) to both eyes. Resident #37 was recently treated for conjunctivitis due to immunodeficiency (week immune system). She was diagnosed with allergic conjunctivitis at the provider visit, with eye gel ordered and to monitor for signs of infection in her eyes. D. Interviews Registered nurse (RN) #2 was interviewed on 8/16/21 at 1:30 p.m. The RN said he was not notified by the SW, LED or CNA #5 that Resident #37's eye was bothering her. He would like to know about the residents he cared for if they had a concern like that so the resident could receive treatment as soon as possible. 44949 III. Physician orders for medication administration 1. Resident #18 A. Resident #18 status Resident #18, age 65, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included Parkinson's Disease, osteoarthritis, and history of falls. The 6/8/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required extensive assistance for activities of daily living. B. Resident interview On 8/11/21 at 11:24 a.m. Resident #18 was interviewed. She said she falls over in the bathroom frequently. She said when this happens she falls into the backside of the toilet or her wheelchair. She said she becomes very dizzy and rigid during these episodes. She said this also happens when she leaves the smoking area to come inside. She said she needs someone to push her wheelchair so a staff member was present. C. Record review On 8/5/21 Resident #18 has an in office neurology appointment. It indicated Resident #18 was reporting dizzy spells involving slumping forward in her wheelchair. The physician suspected low blood pressure and ordered Florinef 0.1 milligram daily. The note was signed and received by the facility on 8/5/21. -However, the medication was not ordered until 8/17/21 (during survey). -Review of Resident #18's medical record did not reveal any documentation relating to the resident's neurological changes (being dizzy). D. Staff interviews (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Certified nurse aide (CNA) #3 was interviewed on 8/17/21 at 2:10 p.m. She said Resident #18 has seizures during every transfer and the resident may call them a fall. She said the protocol was to stay with her to make her feel safe. CNA #3 said she was unsure whether every seizure was reported to the physician.

Licensed practical nurse (LPN) #3 was interviewed on 8/17/21 at 2:42 p.m. He said Resident #18 occasionally had seizures. He said he marked it in the progress notes and reported it to the physician. He said he did not think these were happening weekly. At 3:05 p.m. he said he followed up with the physician and clarified that these episodes during transfers were not seizures, but episodes of rigidity related to diagnosis of Parkinson's Disease.

LPN #1 was interviewed on 8/18/21 at 9:02 a.m. She said Resident #18 called episodes of dizziness falls or seizures but they were not. She said they are episodes of freezing and dizziness. She read the neurology physician's orders dated 8/5/21 and located the corresponding orders in the resident's CPO. She said this medication was added on 8/17/21. She said when a resident went to an office specialist visit and returned with medication orders, it was the floor nurse's responsibility to call the primary care physician. She said if the primary care physician was in agreement with the specialist, the orders would get added.

The director of nursing (DON) was interviewed on 8/18/21 at 9:20 a.m. She said that if a resident returns from a specialist visit with new orders, those orders should be added within 24 hours. She said a two week delay should not happen and she was unsure what happened in this case.

2. Resident #50

A. Resident #50 status

Resident #50, under age 65, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPOs), diagnoses included hemiplegia and hemiparesis, depression, and chronic pain.

The 4/14/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status assessment score of 15 out of 15. The resident required maximal assistance for activities of daily living. The resident had no behaviors impacting care.

B. Record review

The DON provided the pharmacy consultation report on 8/17/21 at 3:30 p.m. The report was dated for 7/29/21. It indicated the acetaminophen order needed a defined parameter for body temperature or to remove fever from the order.

As of 8/17/21 the acetaminophen order continued to instruct for two tablets to be given by mouth every four hours as needed for pain one through five or fever.

Resident #50 received pain medication. The Oxycodone order read as follows: give five milligrams every four hours for pain six to 10 (out of 10 on a pain scale).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the July and August 2021 medication administration record, Resident #50 was receiving this medication six times a day regardless of pain level. Pain was recorded at six or above on two occasions during the month of July 2021 and three occasions during the month of August 2021. C. Staff interviews LPN #1 was interviewed on 8/18/21 at 11:37 a.m. She said that Resident #50 took Oxycodone for pain that is a six to 10. She said when the resident was administered Oxycodone, it was effective for pain. She said the resident was administered Tylenol (acetaminophen) for pain that was a one through five. She said the Oxycodone was scheduled and the parameters that were included in the order were confusing. DON was interviewed on 8/18/21 at 4:24 p.m. She said if parameters were in an order, they should be followed accordingly. 3. Resident #1 A. Resident status Resident #1, age 93, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included type two diabetes, dementia, coronary artery disease, hypertension, cataracts and dry eye syndrome with bilateral lacrimal glands. The 5/5/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief mental status (BIMS) score of two out of 15. The resident required limited assistance of one person for bed mobility, transfers, bathing, hygiene, dressing and toilet use. He required supervision for mobility and eating. The resident was coded for not exhibiting verbal behaviors directed towards others. The resident was coded for having adequate vision without glasses. B. Record review The January 2021 medical administration record (MAR) was reviewed on 8/18/21. The January 2021 MAR did not have an order for Refresh Optive Sig-1gt, as ordered by the eye doctor on 12/28/2020. The August 2021 MAR was reviewed on 8/18/21. The August 2021 MAR did not have an order for Refresh Optive Sig-1gt, as ordered by the eye doctor on 12/28/2020. The resident's comprehensive care plan was reviewed on 8/17/21. The care plan revealed Resident #1 has a history of losing his eye glasses. The care plan did not include an intervention to secure his glasses or prevent him from misplacing them. The resident's social services progress note on 12/28/2020 revealed the resident was seen by the eye doctor. The resident's progress notes from the date of the last eye doctor appointment on 12/28/2020 were reviewed on 8/17/21. The resident did not have any notes regarding the prescription for Refresh Optive Sig-1gt as ordered by the eye doctor on 12/28/2020. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Glucometer calibration 1. Resident #56 A. Resident #56 status Resident #56, age 91, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included type two diabetes, dementia, and chronic obstructive pulmonary disease. The 7/20/21 minimum data set (MDS) assessment revealed the resident had a severe cognitive impairment with a brief interview for mental status score of one out of 15. The resident required extensive assistance with activities of daily living. It indicated the resident was receiving insulin injections. B. Observations On 8/16/21 at 12:24 p.m., a staff member notified LPN #3 about concerns regarding Resident #56. Resident #56 was in bed with her mouth open and looking at the ceiling. LPN #3 entered the resident's room. He checked her blood sugar and asked the resident to squeeze his hand. At 12:30 p.m., he asked for a registered nurse (RN) to come assist. At 12:33 p.m., the DON arrived, entered the room and shut the door. At 12:30 p.m., the staff decided to send the resident to hospital as they suspected a stroke. LPN #3 reported blood sugar was recorded at 150 milligrams per deciliter (mg/dL). At 12:48 p.m., emergency medical services (EMS) arrived. EMS took vitals and reported blood sugar at 61 mg/dL. LPN #3 reported that resident's blood sugar was at 150 mg/dL at 12:30 p.m. EMS checked blood sugar again and reported it was at 61 mg/dL. At 12:51 p.m., LPN #3 notified physician of change of condition. Resident #56 left with EMS. C. Interviews LPN #6 was interviewed on 8/18/21 at 6:18 p.m. She said she was unsure where the glucometer audit was. She said it was her first night working. She located the glucometer audit form. She said each form was resident-specific and the glucometers were labeled for each resident. She did not find the August 2021 form for Resident #56. DON was interviewed on 8/18/21 at 7:24 p.m. She said the night nurses conducted weekly checks of glucometers and the staff development coordinator collected the audits monthly once complete. She said she was not aware that Resident #56 did not have an audit form for August 2021. She provided the audit form for July 2021. She then asked LPN #6 to create a form for August 2021. 44997

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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 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** 43134 Based on observations, record review and interviews the facility failed to ensure three (#24, #22 and #65) out of five residents with limited mobility received appropriate services, equipment and assistance to improve maintain and/or prevent further decrease in range of motion (ROM) out of 32 sample residents. Specifically the facility failed to: -Ensure Resident #24 and #65 received restorative range of motion exercises according to their plan of care; and, -Ensure Resident #22 received restorative nursing services and splinting assistance (palm guards) per therapy recommendations, to improve, maintain or prevent worsening of contractures and protect skin integrity. Findings include: I. Resident #24 A. Resident status Resident #24, under the age of 65, was most recently admitted on [DATE] from hospital after several years in the facility. According to the August 2021 computerized physician orders (CPO), the diagnoses included quadriplegia, hypertension, contractures of right and left hand, wrist, and feet and conjunctivitis of the right eye. The 7/13/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with an unknown brief interview for mental status score (BIMS). He required total assistance with bed mobility, transfers, toileting and dressing; he required total assistance from one person for personal hygiene and was unable to walk or eat. He was totally dependent on staff for bathing. He was impaired in both his arms and legs due to quadriplegia. He did not receive physical, occupational or restorative therapy during the look back period. B. Observations On 8/11/21 at 10:00 a.m. Resident #24 laid in his bed with his head tilted to the left, and both of his hands, elbows and feet had severe contractures. C. Record review The 7/22/21 physical therapy evaluation read that the resident was assessed to prevent new or worsening contractures with discharge recommendations for restorative therapy with a new functional maintenance program (FMP). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The restorative recommendations from the 7/22/21 evaluation referenced the physical therapy discharge FMP from 3/19/2020 and to perform range of motion exercises (ROM).The exercises included gentle ROM to both elbows and wrists due to the increased tone (loss of ROM). The care plan last updated on 6/7/21 read the resident had a restorative program plan of care because he was dependent on staff for mobility and all cares due to quadriplegia with bilateral hand and wrist contractures. He needed to be seen daily for 15 minutes for each task, massage and stretch and ROM to both arms and both legs. The ROM exercises for July and August of 2021 were documented under the tasks section on the electronic medical record EMR for each resident. The ROM tasks read Resident #24 received ROM exercises one time on 8/15/21. The restorative progress notes were for the restorative exercises and tasks completed for the week. There were no restorative weekly notes after 7/29/21 therefore, Resident #24 did not have a restorative progress note for a minimum of two weeks. It did not read that the resident refused restorative therapy. D. Interviews Restorative certified nurse assistant (RCNA) #4 was interviewed on 8/17/21 at 3:00 p.m. He said that he picked up extra shifts to help with staffing, and was pulled to the floor about once a week from the restorative program (cross-reference F725 sufficient staffing). He was the one RCNA on Thursdays. The restorative book had the residents with their FMPs. He said residents were not assigned to specific RCNAs because they worked different shifts and usually one RCNA was available to perform restorative therapy each day of the week. He said he worked with Resident #24 before, however he did not work with him regularly. The director of nursing (DON) was interviewed on 8/18/21 at 3:45 p.m. She said she was the restorative program nurse. The FMP was given to the restorative nurse as a recommendation for each resident who was discharged from therapy. The FMP was then used to create the program for each resident and a copy was placed in the restorative therapy book. The restorative tasks were documented in the electronic medical record (EMR) by the RCNAs. The residents' care plan was then updated with their individualized restorative program. II. Resident #65 A. Resident status Resident #65, age 66, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included Parkinson's disease, peripheral vascular disease, dementia, muscle weakness and hypothyroidism. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/28/21 quarterly minimum data set (MDS) assessment revealed the resident was cognitively impaired and a brief interview for mental status (BIMS) that was unknown because the resident was rarely or never understood. He required two or more persons total assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. He required total dependence on one staff member for eating, he was not able to walk and required total assistance for bathing. He had impairment of both his arms and legs due to Parkinson's disease. He did not receive physical, occupational or restorative therapy during the look back period. B. Observations On 8/12/21 at 9:30 a.m. Resident #65 was on his bed with the lights and television off. He had visible contractures to his knees that were bent with his legs folded all the way. His hips were twisted to the right while his torso was more facing forward. C. Record review The 1/25/21 therapy evaluation read the resident had contractures that measured; the right hip at 115 degrees, the right knee 120 degrees and the dorsiflex (foot) was two degrees. The measurements for the left hip was 111 degrees, the left knee 120 degrees and the dorsiflex (foot) was four degrees, that read Resident #65 had major contractures of his legs. The tasks for July and August of 2021 were documented in the electronic medical record EMR by the RCNAs after they were completed. The document read Resident #65 his brace was applied to his hands and transferred to his reclining wheelchair on 8/17/21. Other than on 8/17/21, the resident did not receive ROM exercises during the last 30 days reviewed until 8/18/21. The care plan last revised on 6/8/21 focused on the restorative program as he was dependent for activities of daily living (ADLs) and had extensive contractures to all his extremities and required assistance a minimum of three times a week to perform ROM exercises, dependent on staff for transfers to his reclining wheelchair and apply braces to his hands according to the restorative plan of care. The restorative progress notes were for the restorative exercises and tasks completed for the week. There were no restorative weekly notes after 7/29/21 therefore, Resident #65 did not have a restorative progress note for a minimum of two weeks. It was not documented that the resident refused therapy. D. Staff interviews RCNA #4 was interviewed on 8/18/21 at 3:00 p.m. He said that he works with Resident #65, three days a week.When the facility did not have enough CNAs to meet the residents' needs, RCNA #4 was pulled to the floor about once a week and picked up extra shifts (cross-reference F725). He provided him with restorative therapy on his scheduled days. He said he was not sure about the other days when he did not work, especially the weekends. The DON was interviewed on 8/17/21 at 5:00 p.m. Resident #65's FMP was used to plan his restorative program to maintain ROM and prevent contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44997 III. Resident #22 A. Resident status Resident #22, age 57, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included nontraumatic subarachnoid hemorrhage from unspecified intracranial artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia (loss of ability to understand or express speech) dysphagia (difficulty swallowing) and abnormal weight loss. The June 2021 annual minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS.) The assessment documented she was moderately cognitively impaired for daily decisions Resident #22 required extensive two-person assistance with transfers, and extensive one person assistance with bed mobility, dressing, hygiene eating, and toileting. She had a feeding tube. The assessment revealed impairment to both upper and lower extremities. The MDS reflected that the resident did not have any restorative services provided during the review period. B. Observations Resident #22 was observed on 8/11/21 at 9:30 a.m. lying in her bed on her back. Her upper body was leaning towards the left and her lower body was turned to the right. Her lower extremities were bent and her hands were contracted. She was not wearing a splint on either of her hands. Resident #22 was observed on 8/12/21 at 9:39 a.m. lying in bed. She was holding a [NAME] Mouse doll with her left hand. Her right hand was contracted and did not have a splint or a washcloth in her hand. She was lying on her back leaning to her left and her lower extremities were bent at the knees. Resident #22 was observed on 8/16/21 at 12:18 p.m. lying in her bed on her back. Her upper body was leaning to the left and her lower extremities were bent at the knees. Her hands were contracted. Hand cream and rolled wash clothes were observed on her bedside table. Resident #22 was observed in the afternoon with the wash clothes in her hands. C. Record Review The August 2021 treatment administration record (TAR) for Resident #22 revealed a daily treatment order to apply splint to resident upper extremities (RUE) and wear for six hours, on at 9:00 a.m. and off at 3:00 p.m. two times a day. The restorative care plan for Resident #22 was revised on 7/19/21, read in pertinent part, The intervention for Resident #22 was to complete twice a day (QD) for 15 minutes each task of bathing/washing/drying right hand, nail cutting to right hand and contracture management with washcloth/palm protector, as well as Passive range of motion (PROM) to both upper extremities (BUE). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The restorative therapy referral for Resident #22 was provided by the restorative certified nursing aide (RCNA) #2 on 8/17/21 at 12:00 p.m. The referral was completed on 6/1/21. The problems identified were decrease in strength and ROM to BUE ' s and decrease in skin integrity, hand hygiene and right hand contracture The goals were to promote skin integrity, decrease risk for skin breakdown and decrease risk for further weakness and loss of ROM and contractures. The interventions are reflected in the current restorative order in the August 2021 plan of care (POC). The functional abilities performance assessment completed on 6/17/21 revealed the resident was dependent for all self care and mobility care needs. Restorative progress notes were documented weekly from 6/9/21 through 7/21/21 with the last weekly note of 7/21/21. -The restorative weekly progress note on 7/21/21 at 4:57 p.m. read PROM to both upper extremities and digits 10 x repetitions, wash/dry with nail care on right hand, contracture management also applied, wash cloth roll with skin checks for any skin issues before and after application, positioning in bed or recliner for comfort. Nurse progress notes: -The nursing progress note on 6/26/21 at 11:24 a.m. reported the splint was not placed on resident because of family visit. -The nursing progress note on 7/8/21 at 10:59 a.m. reported splint cannot be located, notified DON and therapy to get another one ordered if needed. -The nursing progress note on 8/11/21 at 10:03 a.m. reported splint was sent to laundry to be cleaned and not applied. -The nursing progress note on 8/18/21 at 1:51 p.m. reflects nurse signature that splint was placed on Resident #22 per order. The July 2021 task list report provided on 8/18/21 at 12:30 p.m. by the regional nurse consultant (RNC) revealed Resident #22 received range of motion to her upper extremities 28 out of 62 opportunities and received right hand hygiene 14 out of 62 opportunities with no refusals noted. The August 2021 task list report provided on 8/18/21 at 12:30 p.m. by the RNC revealed Resident #22 received range of motion to her upper extremities and hand hygiene four out of 28 opportunities with no refusals noted. 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	RCNA #2 was interviewed on 8/17/21 at 11:29 a.m. She said there were three restorative aides offering the restorative program seven days a week. She said the therapy department evaluated the resident, created a restorative program and then the director of nursing (DON) set up the program in the resident ' s plan of care (POC). She said the program usually runs for three months with a minimum of three visits per week. She said it was only the RCNAs who provided range of motion and the floor CNAs did not provide the restorative program for the residents. She said they did not write daily progress notes after each visit, instead they wrote weekly notes. She said some of the residents were not getting the ordered amount of visits because RCNA #1 was on vacation for ten days and RCNA #3 worked weekends and had been getting moved from restorative to work the floor as a CNA (cross-reference F725). RCNA #2 said Resident #22 was referred to the restorative program on 6/1/21 and was getting restorative services for her right hand contractions, range of motion for her digits and was currently getting a washcloth rolled up and placed in her hands daily. She said she did not know about Resident #22 having a splint in the laundry and said she has not yet been assessed for a splint.

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F 0689 Level of Harm - Minimal harm or potential for 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** 39260 Based on observations, record review and interviews, the facility failed to ensure supervision and assistive devices to prevent accidents for one (#12) of five residents reviewed for falls out of 32 sample residents. Specifically, the facility failed to ensure the fall mat was in place when the resident was in bed to prevent injury as according to the care plan. Findings include: I. Facility policy and procedure The Fall management and investigation policy dated 9/18/18 was provided by the nursing home administrator (NHA). It read in pertinent parts, Five stars utilizes all reasonable efforts to provide a system to review residents potential risk for falls and provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify resident's continued needs. Care plan is developed that addresses potential risk factors for falls and recommended interventions. Fall interventions are documented in the resident record. II. Resident status Resident #12, age 78, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included legal blindness and difficulty walking. The 5/12/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental (BIM) status score of nine out of 15. He required extensive assistance with transfer and total dependence with bed mobility. III. Observations On 8/11/21 at 9:50 a.m., on 8/12/21 at 2:00 p.m. and on 8/17/21 at 10:00 a.m.,the resident was lying in bed. The bed was in the low position. The fall mat was o folded at the foot of the resident's bed. The fall mat was not placed by the resident's bed. IV. Record review The 2/2/21 care plan revised on 6/28/21 identified the resident was at risk for falls related to history of falls, mobility limitations, weakness, discomfort, some memory loss, poor safety awareness at times and use of psychotropic medications. Some interventions were to ensure resident's call light was within reach and ensure resident was wearing appropriate fitting footwear and clothing, make sure frequently used objects, call devices are within reach and in working condition and will provide a safe environment free of clutter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan failed to include a fall mat at the bedside when the resident was in bed as indicated in the post fall reviews. (see below) The Post falls reviews for falls on 6/28/21 and 8/6/21 were reviewed and documented the resident was on frequent checks for fall intervention and safety equipment (low bed and fall mat) were in place. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/18/21 at 10:00 a.m. She said sometimes the resident would roll out of bed onto the floor. She said the fall mat was to be placed in front (parallel) of his bed all the time when the resident was in bed. She said sometimes the staff forget to put the fall mat by the resident's bed. She said the mat was there to prevent the resident from getting hurt if he falls. Registered nurse (RN) #1 was interviewed on 8/18/21 at 11:30 a.m. He said the resident usually rolled out of bed onto the floor. He said the fall mat should be by the bed whenever the resident was in bed to prevent injury from fall. He said sometimes when the staff go to assist the resident, they would remove the fall mat and forget to put it back. He said he would remind the staff to put the fall mat by the resident's bed after care was provided. The director of nursing (DON) was interviewed on 8/18/21 at 2:30 p.m. She said it was important to have the fall mat by the resident's bed when the resident was in bed. She said the resident was found on the floor twice. She said she would provide education to the staff to ensure fall mat was by the resident's bed at all times while he was in bed to prevent injury.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on observations, record review and staff interviews, the facility failed to provide the appropriate care and services for one (#22) of two residents reviewed for enteral nutrition out of 32 sample residents. Specifically, the facility failed to provide enteral feedings according to the physician orders for Resident #22 Findings include: I. Facility policy and procedure The Enteral Nutrition Guidelines policy, last revised 9/1/18, was provided by the Nursing Home Administrator (NHA) on 8/24/21 at 8:41 a.m. It read in pertinent parts, The nurse administers the enteral feeding regimen according to formula, system, type and method of delivery ordered by the physician. Physician's orders are documented in the medical record and include the following: -Size and type of tube; -Insertion of tube and frequency of change (if applicable); -Name of formula, total calories, and flow rate. Total volume in a 24 hour period; -Method of administration (gravity, bolus, pump); -Amount and frequency of water to flush the tube (including before/after medications); -Frequency of residual checks and what amount to report to the physician; -Number of hours to run the continuous drip; and -Stoma site care, if a gastrostomy or jejunostomy. The care plan includes information on: -Who should provide cae and how often; -Immediate and long term goals of the enteral feedings; and -Anticipated duration of the enteral feeding. II. Resident #22 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #22, age less than 60, was initially admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included nontraumatic subarachnoid hemorrhage from unspecified intracranial artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia (loss of ability to understand or express speech) dysphagia (difficulty swallowing) and abnormal weight loss. The June 2021 annual minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS.) The assessment documented she was moderately cognitively impaired for daily decisions Resident #22 required extensive two-person assistance with transfers, and extensive one person assistance with bed mobility, dressing, hygiene eating, and toileting. She had a feeding tube. II. Record review A. CPO for enteral feeding The August 2021 CPO revealed the following physician orders for enteral feedings: -Two times a day Jevity 1.5 via Percutaneous endoscopic gastrostomy (PEG); pump 55 ml/hour for 18 hours up at 4:00 p.m. and down at 10:00 a.m. to provide 990 ml/1485 cal -every shift Head of bed > 30 degrees during feedings -six times a day Flush 150 ml water via PEG -Nutritional Supplement one time a day Sugar Free (SF) ProStat advanced wound care (AWC), 30 ml via PEG -every shift flush PEG with water before and after medication administration B. Care plan for enteral feeding The enteral feeding section of the comprehensive care plan, last revised on 7/19/21, documented, Resident #22 required the need of an enteral feeding due to dysphagia from history of cerebrovascular accident (CVA) and a diet of nothing by mouth (NPO). Pertinent interventions included: -Monitor/document/report as needed any signs of symptoms of aspiration, fever, shortness of breath, tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distention, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. -Resident #22 was dependent on tube feeding and water flushes. -The resident needs the head of the bed maintained at an angle of 30-45 degrees before starting a feeding/med pass and for at least 45-60 minutes afterwards. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required the nurse to irrigate, check patency, and tolerance pre/post medication and enteral administration, and provide fluid flushes as ordered. -Please see the nutrition care plan for the current enteral nutrition regimen. -Skin around the feeding tube needs to be kept clean and free from irritation and/or infection, nurse to routinely evaluate the site for signs of redness, tenderness, drainage or erosion and treat areas as ordered. The nutrition section of the comprehensive care plan last revised on 7/19/21, documented, Resident #22 was dependent on tube feedings for enteral nutrition due to dysphagia related to CVA. -The resident was NPO but the care plan reported that staff will encourage her to drink fluids on each shift. -Provide enteral feeding as ordered. -Provide and serve supplements as ordered: SF Prostat AWC 30 ml daily via PEG. -The registered dietician (RD) to evaluate and make diet change recommendations as needed (PRN). C. nutritional evaluation The 5/28/21 RD nutritional evaluation documented Resident #22 was dependent on tube feeding for enteral nutrition due to dysphagia related to cerebrovascular accident stroke (CVA). She received a high fiber formula for bowel management and an additional protein supplement for history of poor skin integrity. Resident #22 was a total dependence on tube feeding, had difficulty swallowing and chewing and had a physician order for nothing by mouth (NPO) D. Review of the medication administration records (MAR) The August 2021 MAR revealed the following information: -The resident received 18 hours of daily enteral feeding according to the current POC reflected by nurse documentation two times a day to start the tube feeding at 4:00 p.m. and end at 10:00 a.m. -The MAR reflects daily feeding specifically on 8/11/21 was given to resident #22. See observation section related to resident not receiving tube feeding on 8/11/21. III. Observations On 8/11/21 at 9:45 a.m. Resident #22 was lying in bed receiving her feeding with the tube feeding pump on and Jeveti bag in place. The Jeveti bag hanging on the intravenous (IV) pole was dated 8/10/21 with a start time of 11:30 p.m. The Jeveti bag had a quantity of 1500 ml. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/21 at 8:50 am, Resident #22 was lying in her bed holding on to a stuffed animal. Her tube feeding pump was not hooked to the Jevity bag, and she was not receiving her tube feeding. The Jeveti bag hanging on the IV pole was dated 8/10/21 with a start time of 11:30 p.m. The Jeveti bag which held a 1500 ml and and was currently turned off with 200 ml left in the bag. On 8/12/21 at 5:12 p.m. Resident #22 was lying in her bed, and was not receiving her tube feeding. The Jeveti bag hanging on the IV pole was dated 8/10/21 with a start time of 11:30 p.m. The jeveti bag has a quantity of 1500 ml and is currently turned off with 200 ml left in the bag. IV. Staff interviews The DON was interviewed on 8/12/21 at 5:00 p.m. The DON reviewed Resident #22's MARs and confirmed she should have 55 ml 1.5 of jeviti tube feeding from 4:00 p.m. to 10:00 a.m. daily. She said it looked like the resident has received her scheduled feedings based on the documentation in the MAR. She went down to Resident #22's room and agreed the feeding tube pump was not running and the Jeviti bag hanging on the IV pole was dated 8/10/21 hung at 11:30 p.m. She confirmed the bag had not been changed for two days and she would ask her evening nurse who just arrived to start Resident #22's tube feeding. The DON was interviewed a second time on 8/12/21 at 5:28 p.m. She said she did not understand until now that Resident #22 had not been given her tube feeding since 8/10/21 and she would go get that taken care of right away. The Registered dietitian (RD) was interviewed on 8/18/21 at 2:20 p.m. She reviewed the Resident #22's current POC and confirmed the enteral feeding orders of 55ml/hour of jeviti and her water intake was 1692 ml daily, which included free water and flushes. She said her June 2021 labs are within normal limits. The RD said she would be concerned about a resident missing a scheduled tube feeding and would be notified by staff if that happened. She said she would be told directly by the nurse or it would be discussed in the morning meeting. She said there should also be documentation to reflect the missed tube feeding and there is not. She said she was not notified of Resident #22 missing a feeding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observations, interviews, and record review, the facility failed to ensure five (#56, #50, #35, #31, #61) of seven out of 32 sample residents received the necessary respiratory care as ordered by the physician. Specifically, the facility failed to: -Ensure oxygen tubing was replaced and labeled for Resident #56, #50, #31, and #61; -Replace damaged oxygen tubing for Resident #35; and, -Ensure residents oxygen administration orders were followed for Resident #31, #56, and #61. I. Facility policy The care and handling of respiratory equipment policy, last updated on 9/17/18, was provided by the regional nurse consultant on 8/17/21 at 11:00 a.m. by the regional nurse consultant (RNC). It indicated, in pertinent part: Equipment should be changed based on the following schedule/manufacturers recommendation or state regulations: Change weekly: Nasal cannula and humidifier. Nasal cannulas were required to be changed weekly. When the oxygen tubing or other respiratory equipment was changed the staff were to ensure continuous oxygen throughout the tubing. II. Resident #56 A. Resident #56 status Resident #56, age 91, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPOs), diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and personal history of COVID-19. The 7/20/21 minimum data set (MDS) assessment revealed the resident had a severe cognitive impairment with a brief interview for mental status score of one out of 15. The resident required extensive assistance with activities of daily living. It indicated the resident was receiving oxygen therapy. B. Record review The physician orders dated 8/15/17 indicated titrate to > (greater than) or=90% SPO2 (oxygen saturation in the blood) as needed for SOB (shortness of breath)/Wheezing as needed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The orders also indicated that as of 7/5/21, oxygen tubing to be changed every seven days. There was no indication of flow rate included in the orders. The respiratory care plan, updated on 8/4/21 indicated oxygen to be delivered via nasal cannula as ordered. C. Observations On 8/11/21 at 2:30 p.m. Resident #56's oxygen tubing was observed connected to the concentrator. The oxygen tubing was dated and labeled with the date of 7/1/21. The nasal cannula appeared dirty with brown tint near the nasal prongs. On 8/11/21 at 4:28 p.m. Resident #56 was in her room seated in her wheelchair. She was not wearing oxygen. The oxygen flow rate from the concentrator was set at 3.5 liters per minute (LPM). III. Resident #50 A. Resident #50 status Resident #50, age 41, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPOs), diagnoses included asthma and personal history of COVID-19. The 4/14/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status assessment score of 15 out of 15. The resident required extensive assistance for activities of daily living. It indicated the resident was receiving oxygen therapy. B. Record review The physician orders, dated 4/7/21, indicated supplemental oxygen to be provided at three liters per minute via nasal cannula at bed time. The orders indicated that as of 7/5/21, oxygen tubing to be changed every week. The respiratory care plan, updated on 4/7/21 indicated supplemental oxygen to be delivered via nasal cannula at three liters per minute at night. C. Observations On 8/12/21 at 9:00 a.m. Resident #50 was in bed. The oxygen tubing was not labeled. The flow rate was set at 3.5 liters per minute and was delivered via concentrator. D. Staff interview On 8/16/21 at 3:43 p.m., LPN #2 was interviewed. She said there was no date on Resident #50 ' s oxygen tubing. She said she was not sure who is responsible for dating the tubing. She said it should be changed weekly. 43134 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #35 A. Resident status Resident #35, age 68, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, dependent on oxygen, hypertension, heart failure, peripheral vascular disease and obesity. The 6/16/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He required total dependence with two or more persons to assist with transfers, total extensive assistance with two or more persons to assist with bed mobility, dressing and supervision with one person assistance to eat. He required oxygen therapy and used a bi-pap machine. B. Resident interview and observations Resident #35 was interviewed on 8/16/21 at 3:34 p.m. He said that he required nine liters of oxygen through his nasal cannula and at times, used his bipap when he slept. On his nasal cannula a hole about the size of one centimeter was on the tubing with a large amount of oxygen leaking from it. He said that he had difficulty breathing like he was short of air. -The nasal cannula tubing used by the resident was dated 4/1/21, four and a half months prior to the observation. C. Director of nursing interview The director of nursing (DON) was interviewed on 8/16/21 at 3:35 p.m. She said the tubing for Resident #35 was changed. The nasal cannula was required per the policy to be changed more frequently. The staff would receive education about oxygen delivery and when the oxygen tubing needed to be changed. 44997 V. Resident #31 A. Resident status Resident #31, age 88, was admitted on [DATE]. According to the August 2021 computerized physician order (CPO) diagnoses included major depressive disorder, chronic obstructive pulmonary disease, chronic respiratory failure and congestive heart failure. The 6/15/21 minimum data set (MDS) assessment revealed that the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) of eight out of 15. She required two-person extensive assistance for activities of daily living (ADLs). She required the use of oxygen. B. Record review (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The June 2021 care plan identified the resident needed staff assistance to set up oxygen and follow the oxygen rate ordered via nasal cannula. The care plan did not specify a flow rate. The August 2021 CPO documented a physician order for continuous oxygen at 2 liters per minute (LPM) The August 2021 treatment authorization request (TAR) documented a physician order to clean the oxygen concentrator and change the mask/cannula and tubing every night shift every seven days. The August 2021 medical administration record (MAR) reflected the oxygen tubing was changed on 8/9/21. C. Observations On 8/11/21 at 1:42 p.m.Resident #31 lying in bed with her nasal cannula (tube to administer oxygen) on and the oxygen concentrator was set at 3LPM. The tubing was not dated. On 8/16/21 at 11:30 a.m. Resident #31 was lying in bed with her nasal cannula on and the oxygen concentrator was set at 3LPM. The tubing was not dated. D. Staff interview The licensed practical nurse (LPN) #2 was interviewed on 8/16/21 at 3:43 p.m. She said the oxygen tubing should be changed and dated weekly. She said it should be done by a nurse. LPN #2 reviewed Resident #31 ' s oxygen orders in her record and confirmed she should be on 2 liters of oxygen. LPN #2 entered Resident #31 ' s room and confirmed the oxygen tubing was not dated and said the concentrator was set at 3 liters and should be at 2 liters. She then stated she changed the liter flow down to 2LPM on her concentrator. 20287 VI. Resident #61 A. Resident status Resident #61, age 88, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, hypoxemia (low oxygen in the blood), osteoporosis, hypertension, dementia, depression. The 7/21/21 quarterly minimum data set (MDS) assessment revealed the resident's cognitive status was unknown with a brief interview for mental status (BIMS) score out of 15 because she was rarely or never understood. She required extensive assistance from two or more persons with bed mobility, transfer and toileting; extensive assistance from one person with dressing and personal hygiene; supervision with one person physical assistance to eat and she was completely dependent on staff for bathing. She required oxygen delivered through a device. B. Observations (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/16/21 at 2:58 p.m. Resident #61 received oxygen through a nasal cannula while she was in her room. The resident ' s oxygen tubing did not have a date for when it had been changed, therefore, it was unknown how long the tubing had been used for. C. Record review The physician order dated 5/11/21 read, Place continuous oxygen via nasal cannula, titrate to oxygen saturation greater than 89%, -The order failed to include how many liters per minute (LPM) were needed to maintain an appropriate oxygen saturation level. The medical record failed to show any evidence that the oxygen tubing was changed according to the order. The 7/5/21 physician order read, change cannula and tubing and oxygen filter every seven days D. Interviews Registered nurse (RN) #2 was interviewed on 8/16/21 at 3:00 p.m. He said Resident #61 did not have a date on the oxygen tubing as well as the resident was on three liters of oxygen without a specific order of how many liters of oxygen flow she needed. The DON was interviewed again on 8/16/21 at 4:30 p.m. She said the resident ' s oxygen orders needed the amount per litre the oxygen was delivered at to ensure they received a safe amount of oxygen. The oxygen tubing for every resident was replaced every weekend by the nurse supervisor and validated by the DON on Monday mornings as part of her rounds. The staff would be provided education on when to change the oxygen tubing and what the orders needed for the residents with oxygen.

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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. 20287 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 had delayed call light response, failed to provide assistance with activities of daily living (ADLs). Cross-reference F676 failure to provide assistance with activities of daily living and F688 for restorative services. Findings include: I. Resident census and conditions According to the 8/11/21 Resident Census and Conditions of Residents report, the resident census was 66 and the following care needs were identified: -54 residents needed assistance of one or two staff with bathing and 12 residents were dependent. One residents were independent. -58 residents needed assistance of one or two staff members for toilet use and three resident were dependent and five residents were independent. -60 residents needed assistance of one or two staff members for dressing and four were dependent and two residents were independent. -35 residents needed assistance of one or two staff members and 13 were dependent for transfers. Eighteen residents were independent. -29 residents needed assistance of one or two staff members with eating and four were dependent and 33 were independent. II. Staffing requirements for each station Broadway had two 12 hour shifts from 6:00 a.m. to 6:00 p.m. One to two CNAs for both shifts. One licensed nurse. University was to have two to three CNAS for day shift, two to three for evenings and night shift two CNAS. One licensed nurse for all three shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Main was to have two to three CNAs for both days and evenings and nights two CNAs. With one licensed nurse for each of the shifts. III. Resident council The review of the Resident Council minutes from March 2021 through August 2021 revealed numerous resident concerns: -Staff walk by room without answering call lights; -Lack of nurse staffing; and, -Staff turnover and use of agency. IV. Resident interviews Resident were identified by facility and assessment as interviewable. Resident #2 was interviewed on 8/11/21 9:59 a.m. The resident said the facility had a lot of new CNAs. He said call lights were always going off and not being answered. He said he hears them constantly. He said the low staffing was on weekends, and thought the day, evenings and nights. Resident #47 was interviewed on 8/11/21 at 10:31 a.m. The resident said the staffing was always low, however did not know why. Resident #36 was interviewed on 8/11/21 at 10:45 a.m. The resident said the facility was short staffed everyday. He said the call light was not answered timely, and when they did answer it, they said they would come back but never did. Call lights can be greater than an hour to be answered. Resident #18 was interviewed on 8/11/21 at 11:07 a.m. The resident said staffing was low, and it was the late afternoons when it could be up to half an hour up to an hour to have the call light answered. Resident #41 was interviewed on 8/11/21 at 2:04 p.m. The resident said it could takes a long time to get call lights answered. She said it could take up to 30 minutes. Resident #33 was interviewed on 8/11/21 at 2:09 p.m. She said the facility did not have enough staff for the residents and they were always low. The majority of the CNAs were from agencies so they were different people from day to day. Resident #33 said she preferred to be up and out of bed and dressed in the morning, however, because the facility had less staff that day and they were busy, she did not get assistance to get out of bed and change out of her pajamas. Resident #50 was interviewed on 8/11/21 at 2:28 p.m. The resident said the facility was short staffed. She said there was one CNA on her hallway (University). She said she had to wait an hour or two to receive assistance to get into bed. She said weekends were an issue on staffing. Resident #31 was interviewed on 8/12/21 at 10:09 a.m. The resident said the weekends were short staffed. The resident reported last weekend there was only one CNA for 20 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #35 was interviewed on 8/12/21 at 10:21 a.m. He said the facility had one CNA during the night shift on 8/11/21 for all the residents. The staff from last night said three CNAs were scheduled to work; however, at the start of their shift, two of the CNAs left the facility because they knew the facility were short staffed CNAs to meet the resident needs for their shift. Resident #34 was interviewed on 8/18/21 at 10:00 a.m. The resident said her call light was not answered timely. She said she had a weak bladder and when she had to wait for the call light to be answered. She said she had a weak bladder and had accidents. V. Observations On 8/12/21 at 11:00 a.m., the restorative certified nurse aide (RCNA #3) was working the floor as a CNA. On 8/17/21 at 10:30 a.m., the RCNA #4 was working the floor as a CNA. On 8/17/21 at 6:00 p.m., licensed practical nurse (LPN) #6 was observed to work University hall as a CNA. The LPN worked on Main as the charge nurse earlier in the day. VI. Interview CNA #9 was interviewed on 8/15/21 at 7:50 p.m. The CNA said that often times there was only one CNA on the Broadway unit. She said that as a result they could not give showers. She said that yesterday was good because they had two CNAs and they were able to give all the showers which were required. She said currently she was the only CNA with one licensed nurse on Broadway. CNA #6 was interviewed on 8/12/21 at 2:25 p.m. The CNA said she worked the facility often from agency, she said the the University and Main hallways were often worked with only two CNAs. She said they were unable to complete all tasks, such as answer call lights timely and assist residents with showers. A staff member, who wished to stay anonymous, was interviewed on 8/12/21at 2:30 p.m. The staff member said the night shift had only two CNAs in the building last night. The staff member said things get skipped such as showers, and took longer to answer call lights. CNA #8 was interviewed on 8/12/21 at 2:38 p.m. The CNA said she had worked the unit (University unit) alone, because there was no other CNA scheduled to work. She said currently the administration were walking the floors, to help answer call lights, however, that did not occur on a regular basis. She said even when there were two CNAs it was difficult to get all tasks done such as showers. CNA #6 was interviewed on 8/12/21 at 3:40 p.m. She said she received report from one night shift CNA because she was the only CNA for the facility. Restorative certified nurse aide (RCNA) #5 was interviewed on 8/12/21 at 3:51 p.m. She said she was a restorative aide and was scheduled for Fridays, Saturdays and Sundays. She was pulled to the floor for Sunday shift and was working an extra shift that day. The central supply staff was pulled to the floor twice that week also. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RCNA#3 was interviewed on 8/17/21 at 11:28 a.m. She said that her primary job was working as a restorative aide, however, she got pulled to work the floor when there was a vacant CNA shift. The RA said she got pulled to the floor yesterday. The RA said two other RAs also got pulled to the floor weekly. The director of nurses (DON) was interviewed on 8/17/21 at 5:37 p.m. The DON confirmed the facility had an issue with staffing. She said agency staffing was used, and that they were actively attempting to hire new staff. She said she has had licensed nurses working the floor as certified nurse aides, and that she has also had to pick up shifts to work as a charge nurse. She said they have recently began working with three staffing agencies, however, at times the agency CNA would call in sick and then there was no coverage. The DON said she was aware showers were not completed at times due to staffing, however, they were to be made up the next day. The DON said the facility was continuing to admit new residents (with staffing shortages). 44997 43134

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to provide appropriate social services for six (#2, #16, #44, #35, #18 and #31) out seven of 32 sample residents to meet the needs and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically, the facility failed to: -Ensure Resident #2 received eye glasses; and, -Ensure Resident #16, #44, #35, #18 and #31 received timely dental services. Findings include: I. Facility policy The Concrete Needs Policy, last revised on 9/2/18, was received by the regional nurse consultant (RNC) on 8/17/21 at 5:00 p.m. It read in pertinent part that the social services department was dedicated to assist the residents to obtain needed adaptive and other medical necessary items, with an example of dentures. II. Eye glasses 1. Resident #2 A. Resident status Resident #2, age 62, was admitted [DATE]. According to the August 2021 computerized physician orders (CPO) diagnoses included, unspecified fracture of shaft of left tibia (shin bone), hypertension, and chronic viral hepatitis. The 5/5/21 minimum data set (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. The resident required supervision with personal hygiene. B Resident interview Resident #2 was interviewed on 8/11/21 at 9:53 a.m. The resident said he had requested to see an eye doctor and to get a pair of reading glasses. He had asked for a pair of sunglasses. However, he had not received any assistance in obtaining reading glasses. C. Record review The June 2021 resident council minutes documented the resident had requested to have a pair of cheap reading glasses (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/9/21 resident council minutes showed the resident requested to see the eye doctor. -The medical record failed to show any evidence that the resident receiving services to obtain glasses. D. Interview The social worker (SW) was interviewed on 8/17/21 at 3:33 p.m. The SW said he was responsible to ensure the resident's received ancillary items. He said that he was not aware the resident had requested to receive a pair of reading glasses and to see the eye doctor. The SW said he had not reviewed the resident council minutes which indicated the resident had requested eye services and eye glasses. 43134 III. Dental services 1. Resident #35 A. Resident status Resident #35, age 68, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, hypertension, heart failure, peripheral vascular disease and obesity. The 6/16/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. He required total dependence with two or more persons to assist with transfers, total extensive assistance with two or more persons to assist with bed mobility, dressing and toilet use, supervision with one person assistance to eat. He did not walk during the look back period for this MDS assessment. He received scheduled pain medication. He required oxygen therapy and used a bi-pap machine. The resident had several teeth missing on the top and bottom of the left side of his mouth. B. Resident interview and observations Resident #35 was interviewed on 8/12/21 at 10:18 a.m. He said the left side of his mouth does not have teeth. He requested to see a dentist to get dentures six months prior; however, he had not seen a dentist. On 8/12/21 at 10:17 a.m. Resident #35 spoke and when his mouth was open the left side of his mouth was edentulous. C. Record review The care plan, last revised on 8/4/21, read Resident #35 was admitted and placed on a rotation for ancillary services and providers, including dentists. Social services were to ensure the resident received the ancillary services in a timely manner. Resident #35's care plan did not have information about his dental status, health or needs. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews The social worker (SW) was interviewed on 8/18/21 at 3:40 p.m. He stated he explained the facility provided services including dentists, as part of his introduction and how the social services department was involved with resident care when the residents were first admitted . If a resident wanted to be seen by an ancillary provider, they needed to let the SW know to add them to the list for them to see the provider. The documentation used the grievance forms for the residents. He also said Resident #35 did not have a documented request to see the dentist and was not aware the resident wanted to see a dentist. The RNC was interviewed on 8/17/21 at 5:40 p.m. She said a grievance form was now completed for Resident #35 and collected from the resident that after being notified he did not have a grievance filed by the facility he needed to see a dentist. 39260 2. Resident #16 A. Resident status Resident #16, age 66, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), diagnoses included type 2 diabetes and Parkinson disease. The 5/20/21 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. The resident was independent with bed mobility and transfer. -Section L (oral/dental status) was not completed. B. Resident interview The resident was interviewed on 8/11/21 at 10:50 a.m. The resident said he had some broken/chipped teeth and needed to see a dentist for implants. He said he was not sure if the dentist came to the facility or if he had to go to an outside dentist. He said no staff offered or asked him if he would like to see the dentist. He said he would like to have his teeth fixed. C. Record review The 2/15/21 care plan revealed the resident had missing/teeth and poor condition requesting implants with the intervention being referred to social services (department). The 3/2/21 care conference notes were reviewed. There was no documentation that the resident was offered ancillary services. 3. Resident #44 A. Resident status (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #44, age 78, was admitted on [DATE]. According to the August 2021 CPO, diagnosis included end stage renal disease. The 7/15/21 MDS revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was extensive assistance with bed mobility and total dependence with transfer. -Section L (oral/dental status) was not completed. B. Resident interview The resident was interviewed on 8/12/21 at 3:30 p.m. She said she had crowns over her teeth. She said her teeth were loose under the crowns and decaying. She said she would like to see the dentist before it got worse. She said no staff had offered her to see the dentist. She said she was not sure when she would see the dentist. C.Record review -The 4/8/21 comprehensive care plan failed to include dental needs. -There was no documentation in the resident's medical record that the resident was offered any ancillary services. D. Staff interviews The social worker (SW) was interviewed on 8/18/21 at 10:30 a.m. He said during care conferences, he would ask the residents for ancillary services (there was no documentation indicating that the residents were offered ancillary services). He said he was not aware that Resident #16 and #44 needed to see the dentist. He said he would follow-up with the residents and ensure appointments were made for Resident #16 and #44 to be seen by the dentist. The director of nursing (DON) was interviewed on 8/18/21 at 3:00 p.m. She said the social service department was responsible for ancillary services. She said the residents should be offered ancillary services and ensure appointments were made for the service the resident would like to get done. She said she would follow-up with social services regarding ancillary services. -No documentation was provided for Resident #16 and #44 before exit on 8/18/21. 44949 4. Resident #18 A. Resident status Resident #18, age 65, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPOs), diagnoses included Parkinson's Disease and dysphagia. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/8/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required extensive assistance for activities of daily living. It indicated the resident had no natural teeth. B. Resident interview Resident #18 was interviewed on 8/11/21 at 11:14 a.m. She said she wears dentures and had issues with the bottom set. She said the bottom set does not fit well and she has issues with glue. She said the dentist made recommendations during her last visit, but she was unsure about the follow up. She said the recommendations were related to getting new dentures. She said she was unsure if the dentist was coming due to COVID-19. She said it can be hard to talk to the social worker (SW). C. Staff interview The SW was interviewed on 8/17/21 at 3:30 p.m. He said the dentist comes once a month and the last visit was at the end of July. He said he has not heard from Resident #18 regarding wanting to see the dentist. D. Record review The dental status care plan was last updated on 8/4/21. It indicates Resident #18 has a preference to utilize the facilitie's dental services and be seen no less than annually. It indicated staff to observe and document issues with chewing such as loose fitting dentures. The dental services report indicates that the last dental visit was dated 9/30/2020. It indicated a recommendation for a clinical trial of lower implants. It did not indicate a date for follow up visit. 44997 5. Resident #31 A. Resident status Resident #31, age 88, was admitted on [DATE]. According to the August 2021 computerized physician order (CPO) , diagnoses included major depressive disorder, chronic obstructive pulmonary disease, chronic respiratory failure and congestive heart failure. The 6/15/21 annual minimum data set (MDS) assessment revealed that the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) of eight out of 15. She required two-person extensive assistance for activities of daily living (ADLs). She required the use of oxygen. The dental section reflected that the resident did not have any dental or chewing problems. B. Record review (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The June 2021 care plan revised on 7/20/21 identified the resident to be placed on ancillary rotation for podiatry, dental, optometry and audiology as needed. The care plan goal is for the resident to be free of any ancillary issues though the next review date. The intervention is that social services will make sure the resident is seen by the necessary ancillary providers at the necessary time. Staff will notify social services if the resident is having any issues that require her to be seen by the necessary ancillary provider. Resident prefers to utilize the facility's dental services and the facility will ensure the resident is seen no less than annually and as needed. The staff will report to the licensed nurse if the resident is having difficulty chewing or if the dentures are fitting improperly. The dietary progress note dated 6/26/21 revealed Resident #31's diet was downgraded to a mechanical soft per the speech and language pathologist (SLP) recommendation. The resident has few lower teeth and has misplaced her upper dentures. The social services progress note dated 10/9/20 was the last note reflecting a visit by the dental hygienist for Resident #31. The 9/10/19 dental service report revealed Resident #31 received extractions and had impressions completed for dentures to be made. The 11/8/19 dental service report revealed the upper dentures were delivered but it was not a good impression. The report stated the dentist would take new impressions and will return with the full upper denture and lower partial denture. C. Resident and staff interview Resident #31 was interviewed on 8/16/21 at 11:30 a.m. She said she was missing her dentures and was eating foods that were soft and easy to chew. She said she did not mind most of the food and likes mashed potatoes and ice cream. She said she did not know who to talk to about her dentures and other items that are missing. She said she did not know who the social worker was for the facility. She said she believes she needed to talk to someone with Medicaid to order new dentures but they cant come into the building because of covid so she will need to wait. The SW was interviewed on 8/17/21 at 3:32 p.m. He said residents were offered ancillary services at time of initial admission assessment or the resident can ask for the services themselves when needed. He siad ancillary services were discussed during the initial care conference but that conversation is not documented. He said residents can notify any staff member if they need to see an outside provider and then he will be notified by the staff member. The staff will notify him directly, with a note or in electronic record or in the morning meetings. The SW said he was not aware of Resident #31 ever having dentures or needing dentures. He said he did not ask the residents during care conferences if they need ancillary services. He said the previous social services director managed the resident ancillary list and he does not have access to that list. He said he was not aware of residents with ancillary concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39260 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional standards in three out of five medication carts. Specifically, the facility failed to label inhalers, insulins, eye drops and remove expired medication from three medication carts according to manufacturer instructions. Findings include: I. Facility policy and procedure The Storage of Medications policy and procedures, revised 1/1/13, was provided by the regional nurse consultant (RNC) on 1/18/21 at 1:00 p.m. It read in pertinent part, Facility should ensure medications and biologicals: have an expiration date on the label, have not been retained longer than recommended by manufacturer or supplier guidelines or have not been contaminated or deteriorated, are stored separated from other medications until destroyed or returned to the pharmacy or suppliers. Once any mediation or biological package is opened, the facility should follow manufacturer/suppliers guidelines with respect to expiration dates for open medications. Facility staff should recall the date open on the container when the medication has a shortened expiration date when open. II. Observations and interviews A. Cart #1 (Broadway unit) On 8/18/21 at 11:09 a.m., medication cart #1 was inspected in the presence of the MDS coordinator who was covering the unit at that time. The following observations were made: -One Combigan solution eye drop was not labeled with an open date. -One Flovent HFA Aerosol inhaler was not labeled with an open date. -Three Fluticasone Propionate inhalers were not labeled with an open date. -One Lantus Solution(Insulin Glargine) was not labeled with an open date -One Combivent Respimat Aerosol inhaler was not labeled with an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS coordinator said all medications should be labeled when first opened. She said the nurse who first opened the medication was responsible to label the medication with the opened date. She said she worked on the cart over the weekend and she opened a new insulin and labeled it with the opened date. She said probably the insulin was finished and the nurse opened another one and did not label it. She said she was not aware the inhalers were not labeled with the open dates and was not sure of the nurse who opened them. She said she would remove the insulin from the cart and call the pharmacy for replacement. She also said she would inquire from the pharmacy regarding the inhalers with no open date. All the above medications were currently being used. B. Cart #2 (Main Hall) On 8/18/21 at 11:20 a.m., medication cart #2 was inspected in the presence of licensed practical nurse (LPN) #4. The following observations were made: -One Humulin R insulin was labeled 6/28/21 with an open date (was not removed from the medication cart after 28 days). -One Pataday Solution 0.1 % (eye drops) was not labeled with an open date. -One Levemir FlexPen Solution (Insulin) was not labeled with an open date. -Two Fluticasone nasal spray was not labeled with an open date. LPN #4 said she was from the agency. She said it was her second day working in the facility. She said she was not aware the medications were not labeled with an open date. She said the nurse who first opens the medication should label it with the open it. All the above medications were currently being used except for Humulin R. C. Cart #3 (University unit) On 8/18/21 at 11:20 a.m., medication cart #3 was inspected in the presence of LPN #1. The following observations were made. -One Lantus solution was not labeled with an open date. -Two Albuteral sulfate inhalers were not labeled with an open date and one expired on 6/7/21. -One combivent Respinant was not labeled with an open date. -One Fluticasone nasal spray was not labeled with an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 said the nurse who opened the medication first should have labeled it with the open date. She said insulins were good for 28 days from the date it was first opened so it was important to label it with the open date. She said the inhalers should have been labeled with the open date. She said she would remove the medication from the cart and open a new insulin and inhaler and label them with the open date. III. Management interview The director of nursing (DON) who was also the infection preventionist (IP) was interviewed on 8/18/21 at 3:26 p.m. She said it was the responsibility for every nurse to label medication when it was opened. She said the medication carts were checked weekly by the unit managers. She said that all medication carts were checked over the weekend and some expired medications were removed from Broadway ' s cart. She acknowledged that the medication carts were not checked thoroughly. She said she would provide education to the nurses to check the medications cart at the end of their shifts to ensure all medications were labeled with open dates and any expired medications removed from the cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observations, interviews, and record review, the facility failed to have an effective infection control program. Specifically, the facility failed to: -Ensure staff members were utilizing appropriate personal protective equipment (PPE). -Offer and assist Residents with hand washing prior to meals and have staff wash hands after providing care. -Conduct COVID-19 testing in appropriate locations with appropriate PPE. -Ensure housekeeping staff were trained in proper infection control. Findings include: I. Appropriate personal protective equipment A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, last updated 4/13/2020, retrieved 8/16/21 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, read in pertinent part, Healthcare Personnel as part of source control efforts, HCP should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. B. Observations On 8/18/21 at 9:32 a.m., LPN #4 was observed in a room with a resident that was on droplet precautions. She could be seen providing care to the resident. She was wearing a disposable gown, gloves, face shield, and cloth mask. The mask which she was wearing was below her nose. Upon exiting the room she was interviewed. She said the resident was sent out to the hospital and upon return was put on droplet precautions. She said she has a physician's note indicating she cannot wear a surgical mask or N95. She said she was told to wear a face shield and her cloth mask. At 9:50 a.m., LPN #4 was observed in the hallway. She was continuing to wear her cloth mask that was worn in the droplet precaution room. She said she would change it. At 10:00 a.m. she returned to the floor with a new cloth mask. C. Director of nursing interview (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/18/21 at 9:40 a.m., the director of nursing (DON) was interviewed. She said LPN #4 should not be entering isolation rooms to provide care since she cannot wear surgical or N95 mask. She said that all staff would need to wear an N95 in order to go into an isolation room. She said she would provide additional training to LPN #4. II. Hand Hygiene A. Professional reference The Centers for Disease Control (CDC) Hand Hygiene updated 5/17/2020, retrieved on 8/16/21 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, revealed in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. Practicing hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate SARS-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The CDC recommends using ABHR with greater than 60% ethanol or 70% isopropanol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. B. Facility policy The DON provided facility hand washing policy on 8/18/21 at 5:02 p.m. It read, in pertinent part: Proper hand washing/hand hygiene technique must be used at all times when indicated. Hand washing is the most important component for managing the spread of infection. Hand washing is performed: 1. Before starting work. 2. When hands are visibly soiled or contaminated with blood or other body fluids. 3. Before and after each resident contact. 4. If moving from a contaminated-body site to a clean-body site during resident care. Alcohol based cleaners: Use for routine decontamination of hands in clinical areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Apply product to the palm of hand. 2. Rub hands together, covering all surfaces until hands are dry. C. Observations On 8/11/21 at 9:55 a.m., certified nurse aide (CNA) #2 was observed in hallway. She entered a droplet precaution room and did not wear appropriate PPE. She entered four additional rooms on the hallway and did not wash hands or use hand sanitizer between rooms. On 8/11/21 at 12:14 p.m., the admissions director (AD) was observed serving lunch to Resident #56. AD did not offer any assistance with hand washing. At 12:18 p.m., AD was observed serving an additional resident. She did not offer any assistance with hand washing. On 8/12/21 at 12:05 p.m. a male resident was served lunch. He was not offered or assisted to perform hand hygiene prior to eating. At 12:07 p.m. a resident was served lunch. She self propelled her wheelchair with her hands in order to move around the facility, She was not offered assistance to perform hand hygiene before she began eating her meal. On 8/16/21 at 12:10 p.m., CNA #7 was observed serving lunch trays to residents. She did not offer assistance to the residents for hand washing. At 12:24 p.m., minimum data set coordinator (MDSC) and AD were observed serving lunch. They entered room [ROOM NUMBER] to serve trays. They did not offer assistance with hand washing or hand sanitizer to the residents. On 8/16/21 at 12:30 p.m. a male resident in the main lobby area was served his lunch, he was not offered to perform hand hygiene and began to eat his meal. At 12:32 p.m. a female resident was not offered or assisted to perform hand hygiene prior to eating. On 8/17/21 at 9:40 a.m., MDSC was observed serving meals to residents. She did not offer assistance with hand washing or hand sanitizer to residents prior to meals. D. Interview On 8/17/21 at 5:00 p.m., the DON was interviewed. She said residents may need assistance with hand hygiene and this should be provided by the staff. She said she would provided education to the staff. III. COVID-19 testing 1. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/11/21 at 9:43 a.m., COVID-19 testing was observed. The staff development coordinator (SDC) was completing the tests on residents. She was observed completed a test on a resident in the hallway. She was wearing a surgical mask and gloves, no other PPE. On 8/12/21 at 9:33 a.m., COVID-19 testing was observed. The SDC had a cart of supplies outside of a resident's room. Three additional facility staff members were seen at the cart with their masks down. The staff members were seen completing COVID-19 tests on themselves. The DON approached the cart and was seen speaking to the staff members. The staff members completed testing and moved masks to cover mouth and nose and walked away. They were not seen using hand sanitizer. 2. DON interview On 8/12/21 at 1:50 p.m., the DON was interviewed. She said the SDC completes the COVID-19 testing. She said the SDC completes testing around the same time everyday and reports the results back to her. She said the tests should be completed in the resident's room. She said during testing, the SDC should wear gloves, N95 mask, eye protection, and gown. She said staff should complete their test upon arrival to the facility and in the SDC's office. She said when testing is done in the hallway or reception area, it puts others at risk. IV. Housekeeping 1. Observations and staff interviews On 8/17/21 at 10:19 a.m., housekeeper (HSK) #1 was observed cleaning a resident's room. She was observed spraying hydrogen peroxide in the bathroom on walls, handrail, and toilet. She then began to use a towel to wipe these areas. She disposed of the towel, removed gloves, sanitized hands, and then donned new gloves. She sprayed a new towel with the hydrogen peroxide and began to clean the sink area. She then used the same towel to clean doorknobs and light switches in the room. Following exit from room, HSK #1 was interviewed. HSK #1 was Spanish speaking and the use of a translator was implemented. She said the dwell time for the hydrogen peroxide was one to two minutes. She said she was not trained on chemicals. She said she was trained on the proper cleaning of residents' rooms. On 8/18/21 at 9:17 a.m., HSK #2 was observed cleaning a resident's room. HSK #2 had gloves on upon entering the room. She emptied the trash. She then went into the bathroom and lifted the lid of the toilet and sprayed it with disinfectant. She then began to wipe this area with a towel. She continued to use the towel to clean the base of the toilet and handles. She returned to her cart and retrieved a spray bottle of Windex. She did not change gloves. She went back into the room and cleaned the sink area. During this, she touched and moved the resident's personal belongings including a drinking cup. She then began to wipe down furniture, television remote, and door handles using the same towel that was used on the sink. She moved items on the beside table while continuing to wear the gloves worn while cleaning the toilet. Following exit from room, HSK #2 was interviewed. She said she had not been training on chemicals at this facility. She said she had training on chemicals at another facility. She did not know the dwell time for the chemical used. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2021
NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Housekeeping supervisor interview On 8/19/21 at 8:11 a.m., the housekeeping supervisor (HSKS) was interviewed. She said there are no full time housekeeping staff under her supervision and they are staffed using a staff agency. She said she had new staff almost everyday and had to complete training with them. She said she did not track this training. She said the typical procedure for cleaning a room involves donning gloves and a mask and entering the room. Then the chemical is sprayed onto the mirror, sink, toilet, and high touch areas. It should then be left for 5-7 minutes and then wiped down. The staff member should then dispose of rag and gloves and sanitize hands and don new gloves. She said the living area should be cleaned and this involves cleaning the blinds, [NAME], and tables. Gloves should then be taken off, hands sanitized, gloves replaced. Then the bathroom is cleaned with one to two new rags being used. The floor is mopped on the way out. She said gloves should be changed about three times. 20287 43134