STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skylake Post Acute	12080 Bellaire WY Thornton, CO 80241

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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 0585 Level of Harm - Actual harm Residents Affected - Few	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. 44121 Based on interviews and record review the facility failed to make prompt efforts to resolve grievances and to keep the residents appropriately apprised of progress toward resolution for two out of five neighborhoods. Specifically, the facility failed to address grievances in a timely manner about receiving bathing according to preferences and improper food temperatures which resulted in residents experiencing feelings of not being heard, not mattering, and frustration that their voices were not heard and concerns were not resolved. Cross-reference citations: F677 the facility failed to provide showers according to resident preferences for Residents #20, #11, #1, #10, #6; and, F804 palatable food temperatures. Findings include: I. Facility Policy The Grievance/Concern policy last revised on 7/1/19, was provided via email on 10/13/21 from the regional quality assurance consultant (RQAC). It read in pertinent part,All residents and/or their representatives may voice grievances/concerns and recommendations for changes. Center leadership will investigate, document and follow up on all formal concerns and grievances registered by any resident. II. Resident interviews A. Resident meeting during survey A resident meeting was held on 10/12/21 beginning at 1:41 p.m. with four alert and oriented residents (#16, #17, #18, and #15) selected by the facility. The residents had the following complaints: (continued on next page)

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

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F 0585 Level of Harm - Actual harm Residents Affected - Few	-All four residents stated the food was served cold, which they felt they discussed in several meetings but was not heard because nothing changed; -All four residents said they were missing clothing and the facility failed to notify them of their determinations during the grievance process; -All four residents said showers were not provided as scheduled. They said that at times they went up to three weeks without a shower. Resident #16 said they would bathe themselves in the bathroom sink. The residents said grievance forms were not filled out, as they did not receive follow up regarding their concerns. They stated the facility was aware of their concerns because these issues were common knowledge and had also been discussed in resident council meetings. The residents reported they consider the facility their home and family. They stated the facility had meetings but nothing ever got done. It made them feel bad and have stopped going to meetings because they felt nothing they said would make a difference. They felt like their voice did not matter because no changes happened after reporting concerns so they felt frustrated. They said they felt like they did not matter and the facility staff could do whatever they wanted to them and they would have no recourse. B. Resident and culinary council minutes The 6/9/21 resident council meeting was held with 29 residents. The minutes documented that the residents had complaints about the meals not being served timely. The facility responded that they were working with staff regarding time management. The facility was in the process of hiring a dietary service manager (DSM). The minutes documented that heated carts had been ordered to keep trays warm, along with acknowledgement of staffing challenges. The 7/14/21 resident council meeting was held with 17 residents. The minutes documented, the residents had complaints of not receiving showers as scheduled and cold food was served in the dining room and on room trays. The 8/11/21 resident council meeting documented the 7/14/21 concerns that were reviewed. The previous concern regarding residents not receiving showers timely revealed 14 residents continued to report there had been no resolution, and continued to not receive showers. Fourteen residents reported the kitchen ran out of food and kitchen staff not being available to address concerns. Fourteen residents continued to have the concern that food continued to be served cold. The culinary council minutes conducted by the dietary service manager (DSM) were reviewed for 8/5/21, 8/12/21, 8/25/21, 9/1/21, 9/8/21, 9/15/21, 9/22/21 and 10/13/21. Menu choices were the primary focus of these meetings. Food temperatures were not specially addressed. However, on 8/12/21 meeting notes revealed salad not being stored properly and delays in meal carts. C. Staff interviews (continued on next page)

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F 0585 Level of Harm - Actual harm Residents Affected - Few	The DSM was interviewed on 10/11/21 at 1:11 p.m. The DSM acknowledged the residents had complaints that the food was often served cold. She explained she was transferred to the facility in July 2021. Beginning in August 2021 she scheduled weekly culinary council meetings with the residents to address concerns regarding the kitchen. She stated the kitchen staff was interested in feedback from residents, families and facility staff to improve satisfaction. The social services assistant (SSA) was interviewed on 10/12/21 at 12:00 p.m. The SSA explained that he assisted with reported grievances and forwarded grievance concerns to the director of nursing (DON) and nursing home administrator (NHA) depending on the severity of the grievance. The social service director (SSD) was interviewed on 10/14/21 at 12:31 p.m. She said that she was being trained by the NHA on how to track the grievances. She was involved in the followup and documentation on the grievance forms. She said that it was her responsibility to talk to the residents, especially after losing their clothing. She said it was the policy of the facility to reimburse for lost items not found. She said the process was to document the results on the grievance form then notify the resident of the results. She said she had recently taken this task over and would be more diligent at documenting the results on the form including the conversation with the residents. She said she was not involved in the food temperature grievances since the DSM was responding to the concerns. She said it would be put into the log but she was not sure as to the reason for the missing grievances from the log. She said she was notified about the grievances concerning missing clothing, hearing, dental and nail concerns.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45676 Based on observations, interviews and record review, the facility failed to ensure that each resident had the right to be free from abuse for six (#3, #7, #22, #23, #19, and #20) of seven reviewed for abuse out of 28 sampled residents. Specifically, the facility failed to prevent a resident-to-resident altercation between: -Residents #19 and #20; -Residents #7 and #3; -Residents #7 and #22; and, -Residents #7 and #23. Findings include: I. Facility policies and procedures The Abuse Prohibition policy, revised on 4/9/21, provided by the regional quality assurance consultant (RQAC) on 10/13/21. The policy read in pertinent parts: -Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. -The Center will implement an abuse prohibition program through the following: Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations. II. Altercation on 10/12/21 between Resident #19 and Resident #20. A. Resident #19 status Resident #19, age 74, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included: Alzheimer's disease and dementia without behavioral disturbances. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. B. Resident #20 status Resident #20, age 81, was admitted on [DATE]. According to the October 2021 CPO, the diagnoses included: dementia without behavioral disturbance and anxiety disorder. The 8/18/21 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. C. Observation of resident to resident altercation On 10/12/21 at 11:05 a.m., 10 residents were observed engaging in a noodle ball activity (each resident had a foam swimming noodle and hit a balloon) in the common area located outside the nurses station. The residents were sitting in a semicircle in chairs with recreational therapy assistant (RTA) #1 standing in the middle tossing the balloon. At 11:12 a.m., Resident #20 was observed yelling sit down and get out of the way at Resident #19, who was standing in the middle of the semicircle next to RTA #1. He motioned to a certified nursing assistant (CNA) to intervene. The CNA intervened and walked Resident #19 down a hallway and left her standing there. At 11:20 a.m, Resident #19 was standing behind Resident #20 who was still sitting in a chair participating in the noodle ball activity. Resident #20 turned around and hit Resident #19 on the head with the noodle. Resident #19 then hit (with her hand) Resident #20, on the right side of the head. Resident #20 yelled, ouch that hurt. The RTA #1 was present, however did not act after altercations and the exclamation by Resident #20 that it hurt. At 11:22 a.m., licensed practical nurse (LPN) #2 was notified of the observed altercation. At 11:45 a.m., the director of nursing (DON) was notified of the altercation since the nursing home administrator (NHA) was not present in the building. D. Facility investigation The altercation was under investigation and not available for review, see staff interviews below. E. Staff interviews The DON was interviewed on 10/12/21 at 11:45 a.m. The DON said that the NHA was the facility designated abuse coordinator, however was not available due to family obligations. She said she received abuse notifications from her staff. She said the process after an abuse allegation was reported began with an investigation into the causes of the incident and provide interventions to prevent future involvements. She said the first priority was to keep the residents safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social service director (SSD) was interviewed on 10/14/21 at 12:31 p.m. The SSD said that the investigation was currently being conducted and the report was not available at this time. She said that she spoke with Residents #20 and #19 and neither resident remembered the incident. The police were called and the family was notified on 10/12/21, after the altercation was reported. The SSD said she spoke with RTA #1 and he said he heard one resident state to get away from here, but did not see the altercation. The SSD said that the kind of stimulation oversight that could be implemented to prevent further resident to resident altercations was by having the recreational therapy director (RTD) create activities that the CNAs could be involved in. The CNAs could provide more oversight. The SSD said that the activities of the noodle game, bowling game, and other tossing style of games would be conducted when there were enough CNAs available to help with oversight. 45527 III. Multiple resident to resident altercations involving Resident #7 A. First resident to resident altercation involving Resident #7 and #22 1. Resident #7 status Resident #7, below the age of 70, was admitted on [DATE] and discharged on [DATE]. According to the September 2021 computerized physician orders (CPO), diagnoses included: dementia with behavioral disturbance and schizophrenia. The 9/26/21 minimum data set (MDS) assessment revealed the resident had modified independence for cognitive skills for daily decision making. Resident #7 displayed verbal and physical behavior symptoms directed towards others, rejection of care, and wandering behaviors. 2. Resident #22 status Resident #22, age 84, was admitted on [DATE]. According to the September 2021 CPO, diagnoses include dementia with behavioral disturbance and mood disorder. The 8/3/21 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of nine out of 15. B. Facility investigation The 8/23/21 facility investigation revealed Resident #22 entered the nurses station with a scant amount of blood on his hand. When the nurse asked the resident what happened, Resident #22 said he had been involved in an altercation with another resident. The other resident was identified as Resident #7. Resident #7 said Resident #22 hit him. Notified police, family and ombudsman. The investigation determined there was some form of altercation that resulted in a superficial scratch to Resident #22. Both residents were separated and Resident #7 was moved to another hall. Resident #7 had a medication review. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care planning meeting took place with Resident #7's daughter. The following interventions were added: Resident #7 allowed to vent if needed. Resident #7 was to be redirected when able to be approached. Snacks were to be offered as a means to redirect the resident. Allow the resident to pace if needed to calm down. The 8/24/21 staff witness statement over phone to the social service director (SSD) documented the following pertinent information: Persons interviewed: Registered nurse (RN) #1 who said, While at the nurses station, Resident #3 approached me with blood on his hand. I asked what happened and he said someone beat him up. He took me to his room; while walking over, Resident #7 was in the hallway and Resident #3 said, This is the guy. I then asked Resident #7 what happened and he stated, This guy (points to Resident #3) hit me with an object. Resident #3 then stated he felt threatened because Resident #7 often tried to start fights. It is unknown who investigated this fight as it was unwitnessed. The 8/24/21 staff witness statement documented the following pertinent information; Person interviewed: certified nurse aide (CNA) #3 who said, I was working on the Aspen unit when a resident hit the other, but I did not see what happened. The nurse told me. 1. Record review The 8/23/21 nurses note revealed that after the altercation between Resident #7 and Resident #22, Resident #7 continued to wander into Resident #22's room. Staff provided redirection to Resident #7 and educated him on the importance of not wandering into Resident #22's room. The 8/23/21 general progress note revealed that although SSD, director of nursing (DON), and NHA attempted to transfer Resident #7 to a new hall, away from Resident #22, this was not done because there were no male rooms available. Instead, a large name tag was placed on Resident #7's current room in hopes of deterring him from entering other resident rooms. The 8/24/21 nurses note revealed that Resident #7 exhibited physical behaviors directed towards others up to five days a week. Wandering occurred up to five days a week and posed a significant risk and/or intrusion to others. Resident #7 was experiencing hallucinations and delusions. IV. Second resident to resident altercation involving Resident #7 and #23 A. Resident #23 status Resident #23, age 82, was admitted on [DATE] and discharged on [DATE]. According to the October 2021 CPO, diagnosis included dementia. The 10/4/21 MDS assessment revealed that the resident was severely cognitively impaired with a BIMS of three out of 15. 1. Facility investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/25/21 facility investigation revealed, Resident #7 entered Resident #23's room and started rifling through Resident #23's possessions. Resident #23 then became upset and told Resident #7 to stop. Both residents approached each other, and Resident #7 began to strike at Resident #23. Both residents were separated and Resident #7 was placed with staff as a means to keep him occupied and redirected. The facility sought to properly place Resident #7. In the meantime, the resident was observed more frequently due to his wandering which often caused conflict with others. No immediate changes to the care plan were made. Notified police, family and ombudsman. The facility interviewed both Resident #7 and #23 but they were unable to recall the events of the altercation, they felt safe at the facility. Resident #23 further stated that he felt safe and ready to leave with his family. The 8/31/21 staff witness statement documented the following pertinent information: The person interviewed: social service assistant (SSA) #2, who said, I did not see the resident to resident altercation. When I arrived the activities person was between the two residents. I assisted with separating the two residents The 8/31/21 staff witness statement documented the following pertinent information: person interviewed: recreational therapy assistant (RTA) #1, who said, Heard housekeeper shout they ' re fighting Just outside 600 hall - fire doors were closed, could not see what was happening. Went through and saw residents Resident #23 and Resident #7, standing face to face outside of Resident #23's room (601) stepped in between until residents separated The undated staff resident interview with Resident #26 read, Resident remembers that there were altercations but does not remember who was involved. The resident feels safe at the facility V. Third resident to resident altercation involving Resident #7 and #22, however it was the second altercation between these two residents. A. Facility investigation The 9/5/21 facility investigation revealed that Resident #7 entered Resident #22's room struck Resident #22 across the cheek. The two residents were separated immediately by staff. Resident #22 was sent to the emergency department where no injuries were noted. Upon return, Resident #22 was placed on a different unit. Notified police, family and ombudsman. On 9/5/21 the facility interviewed Resident #22 who stated, Yesterday a [AGE] year old came into my room and beat the crap out of me. I hit him back. He comes in here a lot. On 9/5/21 the facility interviewed Resident #7 who said he was unable to recall events. Resident #7's plan of care was updated to include a medication review, a plan to seek new placement, and increased supervision with one-to-one observation when the resident allowed. The resident interview statements revealed that the persons interviewed: Resident #5's statement was that the resident felt safe at the facility. Resident did not remember who altercations were with. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident interview statements revealed that the persons interviewed: Resident #26's statement was that the resident felt safe at the facility. Resident #26 remembered there were altercations but did not remember who was involved. The 9/5/21 staff interview statement with RN #2 read, I observed resident (#7) straddling (Resident #22) and punching him in the head repeatedly with a closed first. Resident (#7) stated that (Resident #22) was the aggressor. Resident (#7) ceased punching when I intervened. After assessment by RN (registered nurse), (Resident #22) was transported to hospital for further evaluation and treatment. The 9/5/21 staff witness statement documented the following pertinent information: person interviewed: RN #3, who said, I was working in the Aspen nurses station, and was alerted by RN #2 , as she ran down the 600 hall stating, ' Oh my god, [NAME] come down here quickly. ' I arrived at Resident #22's room, where he was laying on the floor on his right side, conscious, but not moving. The nurse stated she witnessed Resident #7 sitting on top of Resident #22, beating him with a closed fist around the head and face. I called 911 from the room, and he (Resident #7) stated, He hit me first. Resident #22 was taken to the hospital by Emergency Medical Services (EMS), (Resident #22) was taken to the hospital by EMS, (Resident #7) was interviewed by (the police department). 1. Record review The 9/6/21 nurses note revealed that Resident #7 was moving furniture out of rooms, lifting heavy tables from the dining room, and was trying to lift a resident's wheelchair while the other resident was sitting in the wheelchair. When told not to do so, Resident #7 became agitated. The 9/7/21 nurses note revealed that Resident #7 exhibited physical and verbal behaviors directed towards others up to five days a week. Other behaviors not directed towards others occurred up to five days a week. Wandering occurred almost daily and posed a significant risk or intrusion to others. Resident #7 also experienced impulsive behaviors and restless walking patterns. The 9/8/21 nurses note revealed that Resident #7 wandered almost daily, and posed a significant risk or intrusion to others. The 9/13/21 assessment note revealed that Resident #7 had become more violent with other residents. The 9/13/21 psychotropic assessment documented Resident #7 had become more violent with other residents. Staff were to provide a quiet environment, approach resident in a calm manner, and to encourage the resident to participate in meaningful activities. VI. Fourth resident to resident altercation involving Resident #7 and second altercation with Resident #23 A. Facility investigation On 9/26/21, Resident #7 was found in Resident #23's room, both breathing heavily and frazzled. Resident #23 reported that Resident #7 attacked him while he was in bed. Resident #7 agreed and stated that Resident #23 attacked him last night in his sleep. There is no noted altercation between the two residents from the previous night. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 had a reddened area and scratches to his head. The two residents were separated and the director of nursing (DON) was notified. Resident #7 persisted on getting him, referring to Resident #23. Director of nursing (DON) was notified and Resident #7 was placed on a one-on-one. Resident #7 placed a fork in his pocket, and refused to give it to the staff. Staff eventually obtained the fork. Physician Assistant #1 was notified. He placed an order to send Resident #7 to the emergency department as he was a danger to others. Resident #7 continued to throw items and police were notified. A police officer interviewed Resident #7, and Resident #7 struck the police officer. Resident #7 was placed on an M1 mental health hold. Resident #7 was discharged from the facility. Police and the ombudsman were notified. The daughter was notified. She was relieved because she was concerned for the wellbeing of Resident #23 because Resident #7 persisted in telling her I am going to get him, referring to Resident #23. Resident #23 was African American, and the daughter stated that Resident #7 had a history of being racist. It was determined that Resident #7 was the aggressor. Resident #7 was discharged from the facility. B. Staff interviews The DON was interviewed on 10/12/21 at 4:45 p.m. The DON said she was aware that Resident #7 posed a threat to other residents. She said he had a flat affect and did not indicate when he would erupt. She said they had one on one (1:1) with him, however he would do better and they would stop it and he would hit another resident. She said Resident #7 at times became more agitated with the 1:1 support from staff and then he would become violent towards staff. She said the staff had to learn to approach and reapproach as Resident #7 allowed. She said they searched for placement but were told he did not qualify for a mental health facility. She said they did not have the resources to care for his aggression towards others. She said they moved other residents away from him that he would target but then he found another resident. She said Resident #7 targeted other male residents that had aggressive tendencies, so she felt it was dominant behaviors from the other residents that triggered him. She said that on the last altercation when the police went to talk to Resident #7, he hit them and was put on a mental health hold at hospital. While Resident #7 was at the emergency department waiting for processing. He entered another person's stall and beat them up. Resident #7 was placed in a mental health facility to address his aggressive behavior towards others. She said the Residents #3, #7, #23, and #25 were no longer residing at the facility. The DON said that when Resident #7 was admitted , the medical records did not include his long history of domestic violence. His daughter reported to the facility that for years Adult Protective Services (APS) had a large file on Resident #7 starting when he lived at home with his daughter. The daughter told the DON, after the third altercation, that she was surprised that the facility was not aware of his long history of abuse. The DON said that the daughter was not able to care for him at home so he was sent to the emergency room for a mental health hold prior to admission to the facility for abusing her and her family members. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The regional quality assurance consultant (RQAC) was interviewed on 10/13/21 at 12:07 p.m. He said the DON was pulled to another facility and he was the point of contact regarding clinical concerns until she returned. He confirmed that Resident #7 was involved in numerous altercations. He said that the facility interdisciplinary team (IDT) implemented a new software product to protect residents. The software could detect certain trigger words in the residents ' medical records to help identify residents with aggressive behaviors. The facility would be able to identify individuals with histories of abuse and domestic violence such as Resident #7. By identifying the aggressive behaviors, the facility could prevent admitting someone into the facility that would not be appropriate in the vulnerable population of the secured unit. The social service director (SSD) was interviewed on 10/14/21 at 12:41 p.m. The SSD said that during a resident to resident altercation she was responsible for speaking to the residents during the investigation. She said she did remember speaking to Resident #7 and the residents he had altercations with but none of them remembered the incidents. She said she remembered numerous times the police were called to intervene for Resident #7 and #3 due to their increased aggression towards other residents. The SSD said that the kind of stimulation oversight that could be implemented to prevent further resident to resident altercations was by having the recreational therapy director (RTD) create activities that the CNAs could be involved in. The CNAs could provide more oversight. The SSD said that the activities of the noodle game, bowling game, and other tossing style of games would be conducted when there were enough CNAs available to help with oversight.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45676 Based on interviews and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for eight (#20, #11, #1, #10, #6) of 10 residents reviewed for bathing out of 28 sampled residents. Specifically, the facility failed to provide bathings according to resident preferences to Residents #20, #11, #1, #10, #6. Cross-referenced to F585 for the facility failing to address grievances in a timely manner about receiving bathing according to residents' preferences. Findings include: I. Resident #20 status Resident #20, age 81, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included: dementia without behavioral disturbance and anxiety disorder. The 8/18/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident required supervision for bathing. A. Record review The bathing records reviewed from 9/1/21-10/14/21 with a total number of bathing opportunities of 14. Resident #20 received two bathings on 9/17/21 and 10/11/21 and refused one bathing opportunity on 9/19/21. The resident received assistance with bathing twice in September 2021 and once in October 2021. II. Resident #11 status Resident #11, age 80, was admitted on [DATE]. According to the October 2021 CPO, the diagnoses included: personal history of traumatic brain injury, vascular dementia with behavioral disturbance, muscle weakness. The 8/4/21 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. The resident required physical help in part of the bathing activity. A. Record review The bathing records reviewed from 9/1/21-10/14/21 with a total possible bathing opportunities of 14. The resident received three bathings on 9/1/21, 9/30/12 and 10/5/21. Resident #11 refused three bathings on 9/16/21, 9/25/21, and 10/7/21. The resident received assistance with bathing twice in September 2021 and Once in October 2021. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident #1 status Resident #1, age 55, was admitted on [DATE], discharged on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the September 2021 CPO, the diagnoses included: type two diabetes mellitus, personal history of other venous thrombosis and embolism, pressure ulcer of sacral region, stage four. The 9/13/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required physical help in part of the bathing activity. A. Record review The bathing records reviewed from 8/6/21-9/13/21, with total bathing opportunities of 10. Resident #1 refused four bathing opportunities on 8/6/21, 8/9/21, 8/13/21, and 8/27/21. The resident received assistance with bathing four times in August 2021 and zero times in September 2021. B. Staff interviews The unit manager (UM) #1 was interviewed on 10/14/21 at 2:04 p.m. The UM #1 said residents were asked upon admission of their preference on bathing. She said a bathing schedule sheet was created. She said if a resident wanted to change the bathing schedule, then the bathing was changed. She said the certified nurse aides (CNAs) documented bathing care provided to residents in the medical record. 44121 IV. Resident #10 status Resident #10, age 86, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included unspecified dementia, history displaced intertrochanteric fracture and depression. The 7/7/21 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. The resident required extensive assistance of one person with bathing. A. Record review The bathing records reviewed from 7/1/21 to 10/13/21 revealed a total possible bathing opportunities of 32. The resident received bathing on 7/7/21, 7/14/21, 8/4/21, 9/1/21, 9/14/21, 9/21/21, 9/30/21, and 10/7/21. Resident #10 received assistance with bathing twice in July 2021, once in August 2021, four times in September 2021 and once in October 2021. C. Resident interviews A resident meeting was held on 10/12/21 beginning at 1:41 p.m. with Residents #15, #16, #17 and #18 selected by the facility. All four residents said showers were not provided as scheduled, and at times they went up to three weeks without a shower. Resident #16 said they would bathe themselves in the bathroom sink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Resident #6 status Resident #6, age 89, was admitted on [DATE]. According to the October 2021 CPO the diagnoses included: Alzheimer's disease, muscle weakness and gait abnormality. The 7/7/21 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for a mental status score of three out of 15. He required extensive assistance from two persons with bathing. A. Observation On 10/11/21 at 1:36 p.m. Resident #10 was observed in the hall of the memory care unit. His finger nails were long with dried brown material on the cuticles and under the nails. The wheelchair seat cushion was dirty with a dried crusty substance. On the left thigh of his jeans were dry reddish brown stains. B. Record review The bathing records reviewed from 7/1/21 to 10/13/21 revealed a total possible bathing opportunities of 32. The resident received bathing on 7/7/21, 7/24/21, 8/4/21, 8/18/21, 9/10/21, 9/15/21, 9/19/21, 9/24/21, 9/28/21, 9/30/21 and 10/7/21. The report revealed the resident refused a shower on 9/21/21. Resident #6 received assistance with bathing twice in July2021, once in August 2021, four times in September 2021 and once in October 2021. C. Resident interviews The regional quality assurance consultant (RQAC) on 10/14/21 at 3:45 p.m. The RQAC said the process for documenting assistance with bathing was primarily in the computerized medical records, however the facility had paper records so the staff were documenting in both places. He said that he understood how the documentation would be incomplete since the staff had several places to document bathing records. He said the facility recognized the concern and implemented a new system for documenting care with bathing in the electronic medical records. He said by documenting in the electronic records the facility staff would be able to pull records to determine if bathing was not being done timely and according to resident preferences.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44121 Based on observations, interviews and record review, the facility failed to ensure food and drink was palatable, attractive, and at a safe and appetizing temperature for two out of five neighborhoods. Specifically, the facility failed to prevent unpalatable food temperatures. Cross-referenced to F585 for not addressing food temperatures to resident satisfaction. Findings include: I. Professional reference Division of Environmental Health and Sustainability, (2019), Colorado Retail Food Establishment Rules and Regulations, (10/26/21), retrieved from: https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view. It read in pertinent part, from 6 CCR 1010-2, 26.7.1; 3-401 (A): The temperature of potentially hazardous foods (time/temperature control for safety foods) shall be 41 F (5 C) or below or 135 F (57 C) or above, at all times, except during necessary periods of preparation or as otherwise provided in this code. Equipment for cooling, heating and holding food, cold and hot shall be sufficient in number and capacity to provide required food temperatures. II. Facility policy and record review The Food: Quality and Palatability policy, last revised 9/17, was provided by the regional quality assurance consultant (RQAC) on 10/13/21. It read in pertinent part, Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. III. Observations of meal service and delivery and interviews. During a tour of the kitchen on 10/11/21 at 1:10 p.m. the dietary service manager (DSM) said that since she started at the facility in July 2021 she made many improvements in the kitchen. She said she reordered the setup of the kitchen to allow for better flow. She stated the kitchen efficiency improved. She said that she was aware residents complained the food was cold. She said there were four staff members in the kitchen when she started. She hired three additional staff so she was left with two open positions to fill. She said most of the meals were served on room trays in the residents ' rooms. The kitchenettes located on resident hallways were not being used due to the lack of nursing and kitchen staff. The kitchen staff collaborated with nursing staff to provide meal service. Current meal service consisted of plating the meals in the main kitchen and sending the meal trays out on carts. She said they did not have enough resources to send the meal trays to the floors so they were using the open carts used for cooling meal items. She said the kitchen staff took the carts to the units and the floor/nursing staff delivered the trays to the residents. She said the kitchen staff no longer had contact with the residents directly due to COVID-19. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff were responsible for getting items from the kitchen that the residents wanted including snacks. She said the kitchen staff were not providing snacks to the units because there was not enough kitchen staff to make the deliveries to the units. She said the floor staff were responsible for coming to the kitchen and requesting any items a resident wanted. She said there was not a set list of snack items that residents required such as someone with diabetes, however, if the staff requested a sandwich the kitchen staff would make it and give it to them. She said she did not take into consideration that the floor staff have to wait on kitchen staff to prepare the snacks for them to take to the residents; and that was more time off the floor from providing care. The kitchen staff was plating the lunch meal onto pallets without heating plates and only using the top dome on numerous plates prior to being placed on meal trays then onto the open cart and out to the floors. The DSM said that she was aware the open cart and not having heated pallets could result in cold food once sent to the residents. She said the palate heater broke about a year ago and they did not have enough top and bottom domes for all the plates. She said they had one heated cart for transporting meals but it was used for residents in isolation. She said she had two insulated carts which went to Aspen and Evergreen units. On 10/13/21 observations made during the breakfast meal revealed the following: -At 6:40 a.m., the dietary service manager (DSM) and dietary service aide (DSA) #1 prepared and plated the resident breakfast meals. -At 6:45 a.m. the following steam table temperatures were documented by the DSM: -Oatmeal 185 degrees -Cream of Wheat 180 degrees, -gravy 170 degrees, -mechanical soft ham 188 degrees -Fruit 41 degrees, -No temperature checks were obtained on eggs and bacon. The DSM said that she took all the food temperatures and was not able to obtain temperatures on the eggs and bacon. During the tray line observations, there were multiple interruptions from facility staff requesting additional items. The DSM reported these requests required additional time to prepare due to an additional check in the resident's healthcare system for dietary restrictions. The regional dietary service manager (RDSM) reported that these additional requests delayed trays being delivered to the units. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the last cart to be delivered to the units revealed the first tray placed on the open cart at 8:37 a.m. and last tray at 9:06 a.m. The open cart was delivered to the unit at 9:07 a.m. CNAs were present to deliver the trays but they had to leave the unit to retrieve the drink cart, which arrived at 9:10 a.m. The staff started serving trays at 9:13 a.m. The staff left the floor to gather condiments, drinks and supplements numerous times during the meal pass. Breakfast tray service was complete at 9:20 a.m. At 9:20 a.m. the test tray consisted of French toast, 76 degrees; and fresh fruit of watermelon, honeydew and cantaloupe, 57.3 degrees. The RDSM was present and acknowledged the fruit was not cold and it was not possible to keep French toast warm for serving. IV. Staff interviews The DSM was interviewed on 10/11/21 at 1:11 p.m. The DSM acknowledged the residents had complaints that the food was often served cold. She attributed this to the building not being equipped for room tray delivery service. In addition, the DSM stated there was not enough equipment to keep meals warm until they were delivered to the resident. The DSM also reported that nursing staff were responsible for serving trays but had other resident care responsibilities which resulted in the delay of delivering resident trays. She said the kitchenettes on each unit were not being utilized due to kitchen and nursing staff shortages. She stated using the kitchenettes would improve the temperature of the meals delivered from the main kitchen. The DSM said that upon her arrival at the facility in July 2021 she immediately made changes to the kitchen to improve efficiency for meal preparation and tray delivery to the residents. She reported there were only four employees working in the kitchen when she arrived. She hired additional staff and continued to recruit for kitchen employees. Reorganizing the kitchen improved meal preparation time by one hour. Previously, breakfast service was not completed until 10:30 a.m. The kitchen was currently able to deliver breakfast trays before 9:00 a.m. The RDSM was interviewed on 10/13/21 at 7:30 a.m. The RDSM acknowledged meal service challenges due to the COVID-19 pandemic and staffing shortages.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45676 Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program to decrease the likelihood of cross contamination for three out of five neighborhoods. Specifically, the facility failed to: -Ensure mattresses were cleaned routinely to prevent odors and dirt build up. -Ensure timely and consistent cleaning of urine in rooms in the common area and empty resident rooms located on the Aspen unit. -Ensure writing utensils were cleaned and stored appropriately after use. -Ensure adequate access to hand hygiene supplies. Findings include: I. Professional reference Centers for Disease Control (CDC), (2021) When and How We Wash Our Hands, retrieved from: https://www.cdc.gov/handhygiene/providers/guideline.html. It read in pertinent part: Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled - Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered -Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. II. Facility policy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Infection Prevention and Control Program policy, last revised 6/7/21, was provided by the regional quality assurance consultant (RQAC) on 10/14/2021 at 12:50 p.m. It read in pertinent part, The Infection Prevention and Control Program is a set of comprehensive processes that address preventing and controlling infections and communicable diseases. Prevention of infection which includes hand hygiene, cleaning and disinfecting equipment. III. Observations On 10/12/21 at 1:30 p.m. a vacant resident room and a common area located at the end of the Aspen hallway was found to be slippery, sticky with dried and wet stains, and had a strong odor of urine. The dirty floors were reported to unit manager (UM) #2. She stated the housekeeping department would be notified immediately. She said one of the residents was urinating in the common area and the vacant room. She said she would look into which resident and provide interventions to prevent it from occurring in the future. She said she thought the housekeeping department was cleaning both areas daily, however the amount of dried and wet stains indicated to her that the cleaning was not being conducted routinely. On 10/13/21 at 9:05 a.m. the following was observed during wound care rounds: -The blue mattress cover in resident room [ROOM NUMBER] had smears of dried on white substance located within the resident's arm reach. -UM #4 used the sharpie attached to her badge to date and initial the new wound dressings, without cleaning in between Resident #27 and #28 wound care treatments. -Resident room [ROOM NUMBER] did not have a paper towel dispenser located above bed B's bathroom sink. The wound care doctor turned off the faucet with her hands after washing and retrieved a paper towel from bed A's bathroom sink. She failed to rewash hands before donning gloves and applying the wound treatment. III. Staff interviews The infection preventionist (IP) was interviewed on 10/14/21 at 11:00 a.m. The IP said that she provided ongoing training for hand hygiene. She was aware it was an important step in maintaining an effective infection prevention and control program (IPCP). She said she was certified by the Centers for Disease Control (CDC) as being an IP at the facility. She said she conducted ongoing observations of staff practices to identify training needs of staff. She said she did not work directly with the housekeeping department since they were contracted. She said their company provided training and ensured compliance with regulations within housekeeping. The IP stated the nurses should be cleaning the writing utensils in between residents and stored appropriately to decrease the opportunity for cross contamination. She said she had included this in training in the past but would educate the nursing staff. The IP stated the floor staff were responsible for cleaning mattresses. She was unsure how often mattresses were cleaned. She said she did not include observing mattresses into the audits she conducted at the facility but would include in the future when doing rounds with staff during resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP stated housekeeping was responsible for cleaning and disinfecting the common areas and vacant resident rooms. She was unsure how often rooms were cleaned. She said she did not discuss the disinfectants and cleaners used in the facility because the housekeeping company was responsible for using the correct products. She said she did not include the housekeeping department in discussions about the different types of infections in the building since the product should be effective for all common contagia. The IP said she had not conducted audits of all resident rooms to ensure that there was ease of access to hand hygiene products like paper towels. She said she did ensure there was alcohol-based hand sanitizer (ABHS) available with frequent interval spacing in hallways and at key hand hygiene stations such as screening when entering the building and in front of personal protective equipment (PPE) stations. She said she would get the paper towel dispenser replaced in room [ROOM NUMBER] immediately. She said the wound doctor should not have touched the faucet after washing her hands and retrieved the paper towel from the other sink, returned with a clean towel to turn off the faucet before donning gloves. She said she trained staff members to perform hand hygiene according to the CDC guidelines. The RQAC was interviewed on 10/14/21 at 12:05 p.m. The RQAC stated that mattresses were cleaned on shower days.