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	04/27/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on interviews and record review, the facility failed to take the necessary steps to ensure two (#4 and #5) of two residents were free from resident to resident abuse out of nine sample residents. Resident #4 was admitted to the facility for long term care on 2/18/22 with diagnoses of dementia, muscle weakness, and unsteadiness on feet. The resident required limited assistance with locomotion on the unit and utilized a walker and wheelchair for mobility. Since admission to the facility on [DATE], the resident wandered around the unit, including into other resident rooms that put him at risk of a resident to resident altercation. The facility failed to address the wandering and provide appropriate person-centered interventions (cross-reference F744 for dementia care). Resident #5 voiced concerns to staff of Resident #4 wandered into his room but there was no follow-up by the facility. Due to the facility not addressing Resident #5 concerns and knowledge that Resident #4 wandered into Resident #5's room and other resident rooms, it led to a resident to resident altercation on 4/3/22. Due to the facility failures, Resident #4 wandered into Resident #5's room and an altercation ensued with Resident #4 having a fall which resulted in Resident #4 sustaining a left wrist fracture, left hip fracture and bruise to scalp (see hospital documentation below). Findings include: I. Facility policy The Abuse Prohibition policy and procedure, revised 4/9/21, was provided by the social services director (SSD) on 4/27/22 at 1:37 p.m. It read, in pertinent part, The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The Center should seek alternative placement for the patient exhibiting the abusive behavior, if warranted. II. Altercation on 4/3/22 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON provided the documents included in the facility incident investigation on 4/26/22 at 11:30 a.m. The investigation included interviews with residents, staff, abuse in-service records, and hospital records. Certified nurse aide (CNA #3 provided a statement on 4/4/22. CNA #3 indicated he heard Resident #5 call out for help on the night of 4/3/22 at 9:20 p.m. When he got to the room he saw Resident #4 was on the floor. Resident #5 said Resident #4 was in his room and he tried to redirect him to his room when he lost his balance and fell . CNA #3 notified the nurse and paramedics came to take Resident #4 to the hospital. Resident #5 was interviewed by law enforcement on 4/5/22. Resident #5 said he was in bed when Resident #4 wandered into his room. Resident #5 got up from bed and told him to leave. Resident #4 grabbed his cane and lost his balance and fell . Resident #5 said he alerted staff to come assist. Resident #5 also reported Resident #4 had come into his room multiple times before and staff had not done anything to stop this. Registered nurse (RN) #2 provided a statement on 4/12/22. RN #2 indicated on 4/3/22 around 9:50 p.m. she arrived on the floor following a break. CNA #3 informed her that Resident #4 was on the floor. RN #2 indicated Resident #4 was on the floor by the bathroom. RN #1 was interviewed by facility staff on 4/13/22. RN #1 indicated she did not see Resident #4 wandering the night of 4/3/22. She said she heard commotion and walked to the Resident #5's room and found Resident #4 on the floor outside of the bathroom. She said he had an injury above his eye and it seemed he had a wrist injury. She said he complained of pain. Hospital records indicated Resident #4 was admitted on [DATE]. Injuries included a hematoma (bruise) to his scalp, left wrist fracture, and left hip fracture. Resident #4 returned to the facility on [DATE]. -There was no interview from Resident #4 included in the facility investigation. III. Resident #4 A. Resident status Resident #4, age 81, was admitted on [DATE], readmitted [DATE] and passed away 4/10/22. According to the April 2022 computerized physician orders (CPO), diagnoses included unspecified dementia, muscle weakness, and unsteadiness on feet. The 2/26/22 minimum data set (MDS) assessment indicated the resident was severely cognitively impaired with a brief interview of mental status score of five out of 15. It indicated the resident required limited assistance with activities of daily living which included locomotion on the unit. It indicated the resident had both a wheelchair and walker for mobility. It indicated the resident wandered and was not at significant risk of getting into a potentially dangerous place and the wandering did not significantly intrude on the privacy or activities of others. B. Record review (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	The behavior care plan, initiated 2/28/22, indicated Resident #4 had a tendency to exhibit sexually inappropriate behavior and was noted to wander into hallways and resident rooms undressed. Interventions included monitoring conditions that may have contributed to inappropriate sexual behaviors, monitoring medications for potential contribution to sexually inappropriate behaviors, and evaluating the nature and circumstances of sexually inappropriate behaviors. -There was no specific care plan for dementia or wandering behaviors or personalized interventions for the resident wandering into other resident's room (cross-reference F744). The DON provided two dementia functional assessment tools that were utilized for secure placement decisions which revealed the following: The assessment from 2/22/22 indicated Resident #4 had memory deficits, difficulty with complex tasks, decreased concentration, and withdrawal from challenging situations. The assessment indicated the resident had wandering behaviors but was not exit seeking. It indicated the wandering was purposeless. The assessment noted the resident was at level four on the global deterioration scale which indicated moderate cognitive decline. The assessment indicated the facility would attempt the general unit before considering a secured memory care unit. The assessment from 3/9/22 indicated Resident #4 was disoriented to time and place, had sleep disturbances, wandered with purpose (looked for a way out), catastrophic reactions, and resistance to care. The assessment noted the resident was at level five on the global deterioration scale which indicated moderate severe cognitive decline. The assessment indicated a chart review would occur and options would be discussed with family as needed. An additional document was attached to the assessment and dated 3/9/22. It indicated the assessment was completed due to repeated instances of the resident wandering into another resident's room. The note indicated the resident's representative was contacted in order to set up a care conference to discuss a secure unit placement and the resident representative declined the care conference. -Although, the facility documented moving the resident to a secured unit on 3/9/22, there was no additional follow-up to include safety measures were put in place to deter the resident from wandering into other resident rooms. Progress notes from 2/18/22-4/10/22 were reviewed and revealed the following: On 2/18/22 a progress note was completed upon Resident #4's admission. It indicated Resident #4 was severely impaired in decision making for daily routine. It indicated when Resident #4 was walking with an assistive device, Resident #4 was not steady but able to stabilize without staff assistance. On 2/25/22 a progress note was completed that indicated Resident #4 undressed and wandered into the hallway and other residents' rooms. On 3/3/22 a progress note was completed that indicated Resident #4 was up during the night and wandered into other residents' rooms. It noted two residents complained because he was in their room and staring at them when they woke up. The note indicated the resident was educated on safety and staying in his room at night. It indicated the resident seems to understand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/24/22 a progress note was completed that indicated Resident #4 was walking in the hallway without his walker. It noted the writer walked with the resident towards his room. The resident attempted to walk into the wrong room. The writer explained it was not his room and was redirected to his room. It indicated Resident #4 was educated on using his walker or wheelchair when ambulating. IV. Resident #5 A. Resident status Resident #5, age 66, was admitted on [DATE]. According to the April 2022 CPO, diagnoses included arthritis, hypertension, and diabetes. The 3/15/22 MDS assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. It indicated the resident did not have physical or verbal behaviors directed towards others. It indicated the resident was independent with activities of daily living and utilized a cane for mobility. B. Resident interview Resident #5 was interviewed 4/27/22 at 8:41 a.m. He said for weeks Resident #4 had wandered into his room and other residents' rooms prior to the altercation with Resident #4. He said Resident #4 would typically come into his room at night. He said he kept his door closed but he could see when Resident #4 entered his room. He said Resident #4 would go to the bathroom and urinate on the floor. Resident #5 said he would clean up the mess himself. He said he notified staff that this bothered him and staff did not have suggestions to reduce this. He said on the evening of 4/3/22, Resident #4 entered his room while he was sleeping and it woke him up. He said he got out of bed and told Resident #4 he was in the wrong room. He said Resident #4 insisted it was his room. Resident #5 walked over to Resident #4 to block his room. He said Resident #4 grabbed his cane and this was the first time Resident #4 had been aggressive towards him. He said there was a struggle between the two for the cane. Resident #5 said he had poor balance and he did not want to fall. He said Resident #4 lost his balance and fell on the floor. He said he yelled for help and nurses came shortly after to tend to Resident #4. He said he did not get injured from the event. He said he believed Resident #4 should have been in the secure unit. He said he had mentioned this to staff. He said the next morning he sent an email to the facility's corporate office and ombudsman in order to clarify the situation. C. Record review The DON provided notes from social services on 4/27/22 at 11:17 a.m. The social services specialist (SSS) completed a document on 3/8/22 based on an interview with Resident #5. Resident #5 stated Resident #4 wandered into his room a week ago. He also noted he observed urine on the floor of his bathroom three days prior. He then stated Resident #4 wandered into his room two days ago and he was able to ask him to leave. The document indicated SSS would write up the report and submit it to the necessary parties. -The action taken after this involved reassessment for the secure memory care unit and an attempt to set up a care conference with Resident #4's representative (see Resident #4 assessment above). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/12/22 a progress note was completed in regards to an interdisciplinary team meeting that discussed the resident-to-resident altercation. It indicated Resident #5 stated Resident #4 wandered into his room to use his bathroom. Resident #5 asked Resident #4 to leave and Resident #4 said it was his room. Resident #4 attempted to grab Resident #5's cane. Resident #4 lost his balance and sustained a fall. Resident #5 contacted staff for assistance. Resident #5 was assessed and no injuries were noted. Provider was notified and no new orders were placed. Resident #5's behavior plan was to be reviewed and revised, he was moved to a private room, and one-to-one supervision was implemented. -However, the one-to-one supervision was implemented nine days after the initial altercation on 4/3/22. Resident #5 provided the email sent to the facility's corporate office and ombudsman on 4/27/22 at 8:53 a.m. It read in pertinent part, The elderly man with dementia who lives directly across the hall from me once again walked into my room to use my toilet; he mistakenly believes that (Resident #5's room) is his and this intrusive behavior has occurred at least a dozen times in the past month or two. Staff is very much aware of his aimless wandering, but has failed to address the problem. As far as I'm concerned, this other resident requires a greater level of supervision in order to ensure everyone's safety. D. Observation During survey from 4/25/22 to 4/27/22 a one-to-one CNA was observed outside of Resident #5's room. The one-to-one CNA accompanied the resident when he left his room. V. Staff interviews The DON was interviewed on 4/26/22 at 11:30 a.m. She said initially the staff thought Resident #4 fell in Resident #5's room. She said the staff were unaware there was an altercation until Resident #5 emailed the corporate office and the ombudsman. She said Resident #5 had never been aggressive but they placed him with a one-to-one CNA in order to ensure safety. -The one-to-one supervision was implemented nine days after the altercation occurred. She said Resident #4 had a wrist and hip injury from the accident and returned from the hospital and was no longer mobile. Licensed practical nurse (LPN) #1 was interviewed on 4/26/22 at 2:55 p.m. She said Resident #4 wandered on the unit. She said the protocol was to redirect the resident to his room. She said residents that wandered and were not redirectable were considered for the secured memory care unit. Certified nurse aide (CNA) #2 was interviewed on 4/26/22 at 3:00 p.m. She said Resident #4 wandered the unit fairly often. She said she would redirect him to an appropriate place and never had any issues redirecting him. She said Resident #4 had a wheelchair and a walker but was forgetful and would not use either. She said she never received training from the facility specific to residents who wandered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	LPN #3 was interviewed on 4/26/22 at 3:12 p.m. She said Resident #4 was a big time wanderer. She said other residents had complained about the wandering. She said staff would redirect him with no issues. She said other residents would also redirect him. The social services director (SSD) was interviewed on 4/27/22 at 8:58 a.m. She said Resident #4 was evaluated for the secure memory care unit but the resident representative was not in agreement and wanted the resident to live in one of the general units. She said upon admission Resident #4 wandered around the unit but was easily redirected. She said staff would tell the resident to go to his room and he did not get upset with the redirecting. She said he was not exit seeking. She said the resident should have a wandering care plan to address concerns but could not confirm if Resident #4 had a care plan. She said Resident #5 complained about the wandering and the unit social worker would have more information. She said she did not know what the follow-up was done when Resident #5 brought up his concerns. The social services specialist (SSS) was interviewed on 4/27/22 at 9:09 a.m. He said Resident #5 complained about Resident #4 wandering into his room. The SSS said he wrote up the interview and gave it to the SSD and the nursing home administrator. He said he was unsure what the follow-up was. He said it was not filed as a grievance. He said the unit manager made an attempt to have Resident #4 moved to the secure memory care unit. The unit manager (UM) was interviewed on 4/27/22 at 9:54 a.m. She said Resident #4 would wander up and down the hallways. She said she recalled one instance when Resident #4 attempted to go into the wrong room. She said she was able to redirect the resident to the correct room. She said Resident #4 never got angry or violent when redirected. She said she had mentioned moving the resident to the secure memory care unit during a staff meeting but there was no follow-up. She said no other interventions besides redirection were trialed. She said there was no wandering specific care plan but there was a care plan for behaviors related to his inappropriate sexual behaviors. She said she was not aware of any incident that involved inappropriate sexual behaviors. She said if a resident wandered, there should be a specific care plan on wandering with personalized interventions. The DON was interviewed on 4/27/22 at 10:46 a.m. She said a resident could wander at the facility as long as they were not exit seeking or causing a disruption. She said the social services department completed the assessment regarding the secured memory care unit. She said she did not hear of any residents complaining about Resident #4 wandering into their rooms. She said she could not speak to Resident #4's care plan specifically but that if a resident wandered there should be a specific care plan on wandering with personalized interventions. The SSD was interviewed again on 4/27/22 at 11:46 a.m. She said moving Resident #4 to the secure memory care unit was discussed during morning meeting with nursing staff and the UM called the family to set up a care conference. She said the family declined the care conference. She said if a family declined a care conference then the staff did not have it. She said nothing further was done regarding moving the resident to the secure memory care unit since he was easily redirected. -In addition, the facility failed to implement safety measures when the family declined to move the resident to a secured unit to prevent the resident from wandering into other resident rooms. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The SSD was interviewed again on 4/27/22 at 12:42 p.m. She said she completed behavior tracking based on progress notes completed by the nursing staff. She said there was no formal behavior tracking system in order to determine the root cause of the wandering. She said Resident #4 wandered mostly in the evenings and it appeared to be related to toileting. She said one incident involved Resident #4 getting undressed and wandering into the hallway in a brief and this may have been related to toileting.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on interviews and record review, the facility failed to ensure one (#4) of one resident reviewed for dementia care of nine sample residents, received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being. Resident #4 was admitted to the facility for long term care on 2/18/22 with diagnoses of dementia, muscle weakness, and unsteadiness on feet. The resident required limited assistance with locomotion on the unit and utilized a walker and wheelchair for mobility. Since admission on 2/18/22, the resident wandered around the unit. The facility failed to address the wandering and provide appropriate personalized-centered interventions. Resident #5 voiced concerns to staff of Resident #4 wandering into his room but no follow-up was provided by the facility. Due to the facility failures, Resident #4 wandered into Resident #5's room on 4/3/22 and an altercation ensued with Resident #4 having a fall which resulted in a left wrist fracture, left hip fracture, and bruise to scalp (see hospital documentation). Cross-reference F600 the facility failed to prevent a resident to resident altercation by implementing appropriate safety measures to prevent Resident #4 from wandering into other resident rooms. Findings include: I. Facility policy and procedures A. The Scope of Service and Core Dementia Care Standards policy and procedure, revised 3/12/18, was provided by the social services director (SSD) on 4/27/22 at 1:37 p.m. It read in pertinent part, The abilities and needs of individuals who have Alzheimer's disease or a related dementia vary and, as such, the care for these individuals requires a specialized approach and specific programming. All individuals deserve to be free from mental, physical, sexual, and verbal abuse or neglet. All behavior has meaning and informs caregivers of underlying experiences or needs that may not be easily expressed in words; careful clinical evaluation is a critically important aspect of quality dementia care. B. The Person-Centered Care Plan policy and procedure, revised 1/15/21, was provided by the SSD on 4/27/22 at 1:37 p.m. It read in pertinent part, Social services staff, as members of the Interdisciplinary Care Team, will participate in developing a comprehensive individualized care plan for each patient. Develop individualized plan of care based upon Social Services Assessment and Documentation, subsequent assessments, Care Area Assessment triggers, and other observations. Review, evaluate and update care plans as required. II. Resident census and conditions (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	The 4/25/22 Resident Census and Conditions documented there were a total of 181 residents at the facility with 53 residents that had dementia (29.3%) and 12 residents with behavioral health (6.6%). III. Resident status Resident #4, age 81, was admitted on [DATE], readmitted [DATE] and passed away on 4/10/22. According to the April 2022 computerized physician orders (CPO), diagnoses included unspecified dementia, muscle weakness, and unsteadiness on feet. The 2/26/22 minimum data set (MDS) assessment indicated the resident was severely cognitively impaired with a brief interview of mental status score of five out of 15. It indicated the resident required limited assistance with activities of daily living which included locomotion on the unit. It indicated the resident had both a wheelchair and walker for mobility. It indicated the resident wandered and was not at significant risk of getting into a potentially dangerous place and the wandering did not significantly intrude on the privacy or activities of others. IV. Record review The behavior care plan, initiated 2/28/22, indicated Resident #4 had a tendency to exhibit sexually inappropriate behavior and was noted to wander into hallways and resident rooms undressed. Interventions included monitoring conditions that may have contributed to inappropriate sexual behaviors, monitoring medications for potential contribution to sexually inappropriate behaviors, and evaluating the nature and circumstances of sexually inappropriate behaviors. -There was no care plan for dementia or his wandering behaviors with personalized interventions to deter him from wandering into other resident rooms. The activities care plan, revised 3/18/22, indicated Resident #4 enjoyed watching television and engaging in favorite activities. -The care plan did not indicate what the preferred activities were nor did it have personalized interventions for his dementia care programming. The DON provided two dementia functional assessment tools that were utilized for secure placement decisions which revealed the following: The assessment from 2/22/22 indicated Resident #4 had memory deficits, difficulty with complex tasks, decreased concentration, and withdrawal from challenging situations. The assessment indicated the resident had wandering behaviors but was not exit seeking. It indicated the wandering was purposeless. The assessment noted the resident was at level four on the global deterioration scale which indicated moderate cognitive decline. The assessment indicated the facility would attempt the general unit before considering a secured memory care unit. The assessment from 3/9/22 indicated Resident #4 was disoriented to time and place, had sleep disturbances, wandered with purpose (looked for a way out), catastrophic reactions, and resistance to care. The assessment noted the resident was at level five on the global deterioration scale which indicated moderate severe cognitive decline. The assessment indicated a chart review would occur and options would be discussed with family as needed. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	An additional document was attached to the assessment and dated 3/9/22. It indicated the assessment was completed due to repeated instances of the resident wandering into another resident's room. The note indicated the resident's representative was contacted in order to set up a care conference to discuss a secure unit placement and the resident representative declined the care conference. -Although, the facility documented moving the resident to a secured unit on 3/9/22, there was no additional follow-up to include safety measures put in place to deter the resident from wandering into other resident rooms to prevent abuse (cross-reference F600). Progress notes from 2/18/22-4/10/22 were reviewed and revealed the following: On 2/18/22 a progress note was completed upon Resident #4's admission. It indicated Resident #4 was severely impaired in decision making for daily routine. It indicated when Resident #4 was walking with an assistive device, Resident #4 was not steady but able to stabilize without staff assistance. On 2/25/22 a progress note was completed that indicated Resident #4 undressed and wandered into the hallway and other residents' rooms. On 3/3/22 a progress note was completed that indicated Resident #4 was up during the night and wandered into other residents' rooms. It noted two residents complained because he was in their room and staring at them when they woke up. The note indicated the resident was educated on safety and staying in his room at night. It indicated the resident seems to understand. On 3/24/22 a progress note was completed that indicated Resident #4 was walking in the hallway without his walker. It noted the writer walked with the resident towards his room. The resident attempted to walk into the wrong room. The writer explained it was not his room and was redirected to his room. It indicated Resident #4 was educated on using his walker or wheelchair when ambulating. V. Altercation on 4/3/22 Resident #4 wandered into Resident #5 room on 4/3/22 where an altercation occurred and Resident #4 was subsequently sent to the hospital. Resident #5 had previously voiced concern to the facility staff that Resident #4 would wander to his room to use his bathroom (cross-reference F600). Hospital records indicated Resident #4 was admitted on [DATE]. Injuries included a hematoma (bruise) to his scalp, left wrist fracture, and left hip fracture. Resident #4 returned to the facility on [DATE]. VI. Staff interviews The DON was interviewed on 4/26/22 at 11:30 a.m. She said initially the staff thought Resident #4 fell in Resident #5's room. She said the staff were unaware there was an altercation until Resident #5 emailed the corporate office and the ombudsman. She said Resident #4 had a wrist and hip injury from the accident and returned from the hospital and was no longer mobile. (continued on next page)

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	04/27/2022

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

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 0744 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 4/26/22 at 2:55 p.m. She said Resident #4 wandered on the unit. She said the protocol was to redirect the resident to his room. She said residents that wandered and were not redirectable were considered for the secured memory care unit. She said she had received dementia training. Certified nurse aide (CNA) #2 was interviewed on 4/26/22 at 3:00 p.m. She said Resident #4 wandered the unit fairly often. She said she would redirect him to an appropriate place and never had any issues redirecting him. She said Resident #4 had a wheelchair and a walker but was forgetful and would not use either. She said she never received training from the facility specific to residents who wandered. LPN #3 was interviewed on 4/26/22 at 3:12 p.m. She said Resident #4 was a big time wanderer. She said other residents had complained about the wandering. She said staff would redirect him with no issues. She said other residents would also redirect him. She said she had received general training on dementia care. The social services director (SSD) was interviewed on 4/27/22 at 8:58 a.m. She said Resident #4 was evaluated for the secure memory care unit but the resident representative was not in agreement and wanted the resident to live in one of the general units. She said upon admission Resident #4 wandered around the unit but was easily redirected. She said staff would tell the resident to go to his room and he did not get upset with the redirecting. She said he was not exit seeking. She said the resident should have a wandering care plan to address concerns but could not confirm if Resident #4 had a care plan. She said Resident #5 complained about the wandering and the unit social worker would have more information. She said she did not know what the follow-up was done when Resident #5 brought up his concerns. The social services specialist (SSS) was interviewed on 4/27/22 at 9:09 a.m. He said Resident #5 complained about Resident #4 wandering into his room. The SSS said he wrote up the interview and gave it to the SSD and the nursing home administrator. He said he was unsure what the follow up was. He said it was not filed as a grievance. He said the unit manager made an attempt to have Resident #4 moved to the secure memory care unit. The unit manager (UM) was interviewed on 4/27/22 at 9:54 a.m. She said Resident #4 would wander up and down the hallways. She said she recalled one instance when Resident #4 attempted to go into the wrong room. She said she was able to redirect the resident to the correct room. She said Resident #4 never got angry or violent when redirected. She said she had mentioned moving the resident to the secure memory care unit during a staff meeting but there was no follow up. She said no other interventions besides redirection were trialed. She said there was no wandering specific care plan but there was a care plan for behaviors related to his inappropriate sexual behaviors. She said she was not aware of any incident that involved inappropriate sexual behaviors. She said if a resident wandered, there should be a specific care plan on wandering with personalized interventions. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 4/27/22 at 10:46 a.m. She said a resident could wander at the facility as long as they were not exit seeking or causing a disruption. She said the social services completed the assessment regarding the secured memory care unit. She said she did not hear of any residents complaining about Resident #4 wandering into their rooms. She said she could not speak to Resident #4's care plan specifically but that if a resident wandered there should be a specific care plan on wandering with personalized interventions. The SSD was interviewed again on 4/27/22 at 11:46 a.m. She said moving Resident #4 to the secure memory care unit was discussed during the morning meeting with nursing staff and the UM called the family to set up a care conference. She said the family declined the care conference. She said if a family declined a care conference then the staff did not have it. She said nothing further was done regarding moving the resident to the secure memory care unit since he was easily redirected. -In addition, the facility failed to implement safety measures when the family declined to move the resident to a secured unit to prevent the resident from wandering into other resident rooms. The activities assistant (AA) was interviewed on 4/27/22 at 12:15 p.m. She said Resident #4 did not participate in group activities. She said she provided leisure packets but he did not complete them. She said she was unsure if he was social or joined activities in the evening. The SSD was interviewed again on 4/27/22 at 12:42 p.m. She said she completed behavior tracking based on progress notes completed by the nursing staff. She said there was no formal behavior tracking system in order to determine the root cause of the wandering. She said Resident #4 wandered mostly in the evenings and it appeared to be related to toileting. She said one incident involved Resident #4 getting undressed and wandering into the hallway in a brief and this may have been related to toileting.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820 Based on observations, interviews and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards, in one of three medication carts and one of two medication storage rooms. Specifically, the facility: -Failed to date insulins when opened; -Failed to discard an expired glucagon emergency kit; -Failed to date an Advair diskus inhaler when opened; -Failed to date tuberculin when opened; and, -Failed to discard expired insulins. Findings include: I. Professional references According to the Tubersol package insert, retrieved 5/2/22 from: https://www.fda.gov/media/74866/download, A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. Prescribing information for Lantus (glargine), retrieved 5/2/22 from: https://products.sanofi.us/Lantus/Lantus.html#section-15, Lantus available in a multidose 10 ml vial and a prefilled 3 ml pen, is viable for 28 days after opening. Prescribing information for Humalog lispro insulin, retrieved 5/2/22 from https://uspl.lilly.com/humalog/humalog.html#ug, After vials have been opened: Throw away all opened vials after 28 days of use, even if there is insulin in the vial. Prescribing information for Humalog insulin, retrieved 5/2/22 from https://uspl.lilly.com/humalog/humalog.html#pi After the vail has been opened, throw it away after 28 days. Prescribing information for Novolog 70/30 insulin, retrieved 5/2/22 from https://www.novo-pi.com/novologmix7030.pdf After the vial has been opened, throw away after 28 days. Prescribing information for Humulin N insulin, retrieved 5/2/22 from https://uspl.lilly.com/humulinn/humulinn.html#ppi After the vail has been opened, throw it away after 31 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prescribing information for Advair diskus, retrieved 5/2/22 from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Advair_Diskus/pdf/ADVAIR-DISKUS-PI-PIL-IFU.PDF ADVAIR DISKUS should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads '0'. II. Observations and interviews The medication cart for the 700 hall was observed on 4/26/22 at 9:22 a.m.: -An Advair diskus opened without a date; -A Humalog insulin vial with the open date of 3/3/22; -A Novolog 70/30 vial with an open date of 3/15/22; -Two Lantus vials with no open date; -A Humulin N vial with no open date; -A pen of Glargine insulin with no open date; and, -An expired Glucagon Emergency kit (expiration date of 12/2021). Licensed practical nurse (LPN) #1 was interviewed on 4/26/22 at 9:22 a.m. She said she did not know the [NAME] had not been dated. She said she was not aware there were expired vials in the cart. She said she was not aware the Advair diskus had a short shelf life once opened from the foil pouch. She said she was not aware the glucagon emergency kit was expired. She said she would notify the unit manager of the medications found. She said the medications that were expired should have been discarded and the other medications should have been dated to ensure the medications were still effective. She discarded the medications. The medication room on the rehabilitation unit was observed on 4/27/22 at 9:08 a.m. The room had an opened vial of tuberculin with no open date. LPN #2 was interviewed on 4/27/22 at 9:08 a.m. She said the vial should have been open when dated to ensure efficacy of the medication. She discarded the vial. The director of nursing (DON) was interviewed on 4/27/22 at 10:48 a.m. She said she was surprised there were that many concerns with the medications. She said every Monday all the carts were to be checked for expired medications and medications not dated. She said it was important to date medications and discard expired medications to ensure efficacy of the medication. She said education will be completed to all the nurses.