STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 43135 Based on record review and interviews, the facility failed to establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf for five (#106, #94, #49, #116, and #97) out of six sampled residents. Specifically, the facility failed to: -Maintain financial records of quarterly statements for five residents (#106, #94, #49, #116, and #97); and -Ensure resident funds were separated from facility funds. Findings include: I. Financial quarterly statements a. Resident interview Resident #97 was interviewed on 3/10/21 at 5:04 p.m. Resident #97 said she does not receive financial statements from the facility. Resident #49 was interviewed on 3/23/21 at 2:00 p.m. Resident #49 was documented as cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15 on the 1/2/21 minimum data set assessment. Resident #49 is her own responsible party for her billing statements. Resident #49 said all last year of 2020 and this year 2021 she had never received a single financial statement. She said there was a newer person in the business office and she had asked several times for her statement but was never given one. b. Staff interview (continued on next page)

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

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Business office manager (BOM) was interviewed on 3/23/21 at 2:00 p.m. The BOM said her employment started in May 2020. She said she j had records of the financial statements given to the residents. She said the procedure was to have the resident sign when she was the manager on duty on Sundays, she personally delivered the financial records to the resident and had them sign that they received the financial record from her. She said if a resident was unable to sign she mailed the statements to their power of attorney or whomever was responsible. She said she would get the statements of three residents who were able to sign on their own to show they received the statements. She said she would get the financial statement information for Resident #49 and she would choose two other random residents for statements. She said she selected two other residents, #106, and #94. She said she would get the financial statements for the last two quarters. She said the quarterly statement would be for 7/1/2020 - 9/30/2020. The other financial quarterly statement would be for 10/1/2020 - 12/31/2020. She said she had not done any statements for 2021 and that they would be completed by 4/2021. The BOM was interviewed on 3/23/21 at 4:45 p.m. She said she was still working on printing the financial records for the three residents. c. Record review The resident fund management service statements were provided on 3/23/21 at 6:20 p.m. by the BOM. The statements were reviewed and revealed for residents #106,# 94 and #49. There were no signatures on any of the financial statements to signify the statements were given to the residents. -Resident #106 had no signatures as proof for receiving the statements for 7/1/2020 - 9/30/2020 and no signatures for statements 10/1/2020 - 12/31/2020. -Resident #94 had no signatures as proof for receiving the statements for 7/1/1202 - 9/30/202 and no signatures for statements 10/1/2020 - 12/31/2020. -Resident #49 had no signatures for receiving the statement for 10/1/2020-12/31/2020. There was no quarterly service statement given for resident #49 for 7/1/2020-9/30/2020. 43909 II. Resident funds The facility trial balance sheet which contained the resident personal needs account information and balances was provided by the business office manager (BOM) on 3/22/21 at 2:23 p.m. Review of the trial balance sheet revealed two accounts were included within the resident funds: -Resident council fund, with a balance of $4780.42; and -Facility electronic benefit transfer (EBT) account, with a balance of $2781.40 a. Staff interview (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The business office manager (BOM) was interviewed on 3/22/21 at 2:35 p.m. The BOM said she had held the position of BOM for a little less than a year and that as far as she knew the resident council fund had always been kept in the same balance sheet as the resident personal funds. She said the facility EBT account had stayed in the same balance sheet as the resident personal funds because direct deposits had continued to be added to that account for a resident who had discharged in April 2020. She said she had been working on fixing this error as she did not know why the facility was still receiving money for a discharged resident. The BOM said residents had access to their money any time during regular business hours and that there was a cash bag locked on nursing carts for evening and weekend transactions. The BOM said resident fund statements were provided to residents upon request and sent out quarterly. She said some resident statements were sent to family members or powers of attorney rather than directly to the resident. The nursing home administrator (NHA) was interviewed on 3/23/21 at approximately 6:00 p.m. The NHA said the resident council fund which was in the trial balance personal needs fund account was money which the resident council raised for different events. She said the money did not belong to any specific resident. The financial compliance lead reviewer with the Colorado department of health care policy and financing via email on 3/23/21 documented that only the resident's personal needs money can be in the account. Any other funds should not be in the personal needs account, such as the resident council fund.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43135 Based on record review and staff interviews the facility failed to provide advance beneficiary protection notification (ABN) for three (#346, #93, #345) out of three residents reviewed out of 62 total sampled residents. Specifically, the residents were not provided with a completed skilled nursing facility-advance beneficiary notice when they continued to reside in the facility and their Medicare-covered services ended. Findings include: I. Professional references According to the Center for Medicare and Medicaid Services (CMS) website: https://www.cms.gov/Medicare/Medicare-General-Information/BNI dated 1/1/21 was reviewed and revealed in pertinent part: Both Medicare beneficiaries and providers have certain rights and protections related to financial liability and appeals under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. According to the CMS website ABN instruction form last modified on 8/3/2020: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf reviewed and revealed in pertinent part: The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. According to the Center for Medicare and Medicaid Services (CMS) website: https://www.cms.gov/search/cms?keys=ABN+nursing+home+regulation: The Medicare Advance Written Notice of Noncoverage February 2020, retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf page 3, read and revealed in pertinent part: All health care providers and suppliers must deliver an Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 when they expect a Medicare payment denial that transfers financial liability to the beneficiary. This includes skilled nursing facilities (SNFs). The ABN helps the beneficiary decide whether to get the item or service Medicare may not cover and accept financial responsibility for it. If the beneficiary does not get written notice when required, the provider or supplier may be financially liable if Medicare denies payment. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. Facility policy and procedure CMS 10123 revised 1/14/19 and again revised 10/30/2020, was provided by the business office manager (BOM) on company letterhead on 3/23/21 at 6:20 p.m. It was titled business office delivery checklist. On page five directions for providing residents with a ABN was read and revealed in pertinent part: must be delivered prior to providing services and allowing enough time for a decision to be made without pressure. III. Record Review Record review for Resident #346, #93 and #345 showed the residents remained in the facility after their medicare part A coverage ended. The advance beneficiary protection notification (ABN) was requested on 3/23/21 at 9:45 a.m. for Residents #346, #93 and # 345. The BOM said there were no ABN forms for the residents requested because the ABN forms were never done. IV. Interview The business office manager (BOM) was interviewed on 3/23/21 at 9:45 a.m. She said she came from another state and was unaware the ABN form needed to be completed. She said for all three residents she gave a notice of medicare non-coverage (NONMC) but not the required ABN. She said she did not know she should have given the ABN until just a few weeks ago. She said an insurance company involved with the facility asked her where the ABN ' s for the residents were located. She said she told them she did not know what an ABN was. She said as far as she knew, no one in her position before she came to the facility did them either. She said it was not a hard process. She said she just did not know it was required. She said she did not know the business office was required to go over what financial changes might occur for the resident with specific services and items the resident may need. She said either she or her assistant would give the ABN forms from now on. She said there was no performance improvement plan in place.

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F 0584 Level of Harm - Minimal harm or potential for actual 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** 43135 Based on observations, and resident and staff interviews the facility failed to provide a comfortable and homelike environment for the residents of the facility for six out of seven units. Specifically the facility failed to ensure and supply the residents with washcloths, and hand towels in 39 rooms. -The residents failed to have cloth towels to use and some residents utilized paper towels to wash themselves. -The residents reported the facility did not allow them to have towels and if the resident found towels they felt it was necessary to hide the towels for future use. Findings include I. Lack of washcloths and hand towels in resident rooms A. Observations Rooms #704, #707, #709, #710, #711, #712, #714, #715, #716, #717, #718, #721, #723, #725, and #726 did not have washcloths or hand towels available in their room on the following dates and times: -On 3/11/21 at 9:12 a.m. and 11:45 a.m., there were no washcloths or hand towels available in these rooms. -On 3/16/21 at 11:21 a.m. there were no washcloths or hand towels available in these rooms. -On 3/17/21 at 10:14 a.m. and 1:52 p.m. there were no washcloths or hand towels available in these rooms. -On 3/17/21 at 10:58 a.m. Resident #92 wetted paper towels to wash her face, neck, and arms. She then used dry paper towels to dry off her face, neck and arms. She threw all the used paper towels in her trash can. -On 3/18/21 at 12:20 a.m. there were no washcloths or hand towels available in these rooms. -On 3/17/21 at 4:21 p.m. - 4:50 p.m. there were no washcloths or hand towels in the following 24 rooms: -Rooms: #104, #106, #108, #109, #110, #111, #112, #202, #203, #204, #205, #206, #208, #304 #306, #307, #309, #401, #403, #404, #405, #406, #408 and #602. -On 3/17/21 at 4:30 p.m.: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had one dirty towel in the room. -room [ROOM NUMBER] had one towel only in a shared room for two residents. II. Resident interviews Resident #288 was interviewed on 3/17/21 at 4:21 p.m. She said we do not get towels in our rooms here. . Resident #10 was interviewed on 3/17/21 at 4:23 p.m. He said we do not get towels here in this facility. He said it was not the facility rules. He said he wished they gave us towels because it would be nice to wash his face with a real towel and not paper towels. An unidentified resident was interviewed on 3/17/21 at 4:25 p.m. He said he liked to wash his face with a washcloth but he was never provided one. He said if he found a towel he would hide it so that he had one for use. Resident #287 was interviewed on 3/17/21 at 4:32 p.m. She said the only reason you see a towel in my room today was because I hid it. She said today was her bed bath day and the staff helped her hide a towel or you would never see a towel in my room. She said she was not provided with towels in the facility. Resident #16 was interviewed on 3/17/21 at 5:15 p.m. He said he would like to have regular towels if the facility had any. He said he had to fight like heck to get a towel in his hands. Resident #49 was interviewed on 3/23/21 at 1:45 p.m. She said we do not have towels here in this facility. She said this was our home and she wished there were towels to use. She said when she can get one she kept it hidden so she had one. III. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 3/17/21 at 4:45 p.m. She said sometimes we run out of towels and then we must go to the laundry to get them. She said the towels were provided by the laundry staff. She did not know why the linen closet had four hand towels, 45 bath towels and several wash cloths and were not provided to the resident's in their rooms. She did not know who was responsible to take them from the linen closet to the resident's rooms. The assistant director of nursing (ADON) was interviewed on 3/17/21 at 4:53 p.m. He said he did not know the routine of how the towels got to the linen closet and then to the resident rooms. He walked into rooms #403, #405, and #406 and he confirmed the rooms did not have towels. He said he would find out why and that he would provide the policy about towels from the company who did their laundry at the facility. The ADON said he did not need to go in every room to see if there were no towels. He said he could see that having no towels in the facility was a widespread problem. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 3/18/21 at 3:05 p.m. The DON said she was unaware of the resident rooms not having towels. She said laundry staff was to pick up dirty laundry three times a day. She said the laundry staff were responsible to clean, fold and restock the towels in the linen closets. She said it was the CNA's responsibility to take clean towels from the linen closets and bring clean towels to each of the resident's rooms. She said she would have the ADON provide the policy for their towels. IV. Record Review The nursing in-service sign in sheet was provided on 3/22/21 at 5:00 p.m. by the ADON. It was read and revealed: The in-service was dated 3/18/21 with the topic documented that the night staff was to place a hand towel and a washcloth on each resident's nightstand every night. The in-service was signed by 25 attendees. 20287

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on interviews and record review, the facility discharged two (#137 and #121) of six residents reviewed, out of 62 sample residents without appropriate and adequate supports in place to ensure a safe transition from the facility to the community. Specifically, the facility failed to ensure: -Resident #137 or the resident's medical power of attorney (MPOA) received accurate, written information related to homecare, thickened liquids, fluid restrictions, and follow up appointments required upon his 2/20/21 discharge; and, -Document the basis for the necessity of transfer and discharge for Resident #121. Findings include: I. Facility policy and procedure The facility discharge policy was requested form the nursing home administrator (NHA) on 3/25/21 at 2:02 p. m., and not received. II. Resident #137 A. Resident status Resident #137, age 51, was admitted on [DATE],readmitted on [DATE] and discharged [DATE] to his brother's home. According to the March 2021, computerized physician orders (CPO) pertinent diagnoses included, cerebral infarction (stroke), pleural effusion, muscle wasting and atrophy, and cognitive communication deficit. The 2/20/21 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required supervision with bed mobility, transfers, dressing, toileting, personal hygiene and eating. He required physical help with bathing. Resident #137 was on a mechanically altered. B. Resident MPOA interview (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's MPOA was interviewed on 3/18/21 at 12:03 p.m. via telephone. She said her brother was discharged in the facility parking lot with a box of medications. She said he was to go home with their other brother, but they were not advised of the need for thickened liquids, MBSS, or the fact that home care would not follow. She said the instructions did not document that he needed a MBSS, or that he was on thickened liquids. She said she was not aware that homecare would not be coming to help him. The MPOA said when he was discharged home he could barely hold himself up, he was weak and had poor balance with his walker. She said someone had to stabilize him when he walked and help him shower. The MPOA said he had to be cued to get dressed. She said she missed one care conference meeting call, and when she called the facility back, the SSD director said sorry, it's over. She did not know the exact date of this call. C. Record review The February 2021 physician's orders were reviewed. On 2/19/21, the physician's orders documented the following: -On 1/20/21, the orders documented speech therapy (ST), evaluate and treat. -On 1/21/21, the orders documented the resident was on a 1500 ml (milliliter) fluid restriction daily. -On 1/25/21 the orders documented the resident was on a regular diet with a regular texture and nectar thick liquids. -On 1/28/21, the orders documented the resident needed a modified barium swallow study (MBSS) to determine the safest diet and rule out aspiration due to right lower lobe pneumonia, dated 1/28/21. -On 2/19/21, discharge home with home health for physical therapy (PT), occupational therapy (OT), and certified nurse aide (CNA). The physician's assistant discharge summary, dated 2/19/21, was reviewed. The discharge summary documented that due to dysphagia and silent aspiration, the resident had required nectar thick liquids. The discharge summary documented that the resident was scheduled for a MBSS while at the facility, but due to some confusion, it was not completed. The note further documented Resident #137 would need a new referral from his personal care provider for a MBSS and close follow up. On 2/20/21 at 2:30 p.m., the nurse note documented discharged home in wheelchair w (with)/ remaining meds (medications) w (with)/ home health services. Transport provided by family. On 2/20/21 at 2:20 p.m., the social service notes documented, Resident discharged to his brothers home per completion of therapy, and per residents request. Resident discharged with all personal belongings, medications, and medication list. Nursing reviewed discharge assessment with resident. Resident was provided education on COVID-19, as well as fall prevention. (company name) Home health accepted resident for PT, OT, and RN (registered nurse) services, but notified SSA (social services assistant) that they could not provide services to his brothers home in [NAME], CO. SSA educated resident to follow up with his PCP (primary care physician) and ask for home health orders from them. Residents brother provided transportation for resident from facility to his home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It indicated the discharge assessment was only reviewed with resident and not the resident's MPOA. The resident did have a cognitive impairment (see MDS assessment above). In addition, there were not speech therapy orders with the resident being ordered a mechanically altered diet. The discharge instructions, signed by the resident, were received from the nursing home administrator (NHA) on 3/18/21 at 9:10 a.m. The discharge instructions documented the resident discharged home to his brother's house. The instructions documented he had cognitive impairment. It documented, homecare for a home health aide (HHA), PT and OT would start on 2/22/21. The instructions documented he was on a regular diet. There was no documentation that he was on nectar thick liquids or a fluid restriction. The instructions, under follow up tests and procedures, were not filled out. On 2/19/21, the day before Resident #137 discharged , the social service notes documented the home care agency notified her they could not follow the resident to the brothers home. However, Resident #137's MPOA were not notified that homecare was not going to follow to the brother's home. The discharge instruction documented a specific home care agency and start date of 2/22/21 with PT, OT and home health aide (HHA). D. Staff interviews The social service director (SSD) was interviewed on 3/17/21 at 10:50 a.m. The SSD said she was notified on Friday 2/19/21, that the homecare agency would not follow the resident to the brother's home. The SSD said she did not notify the physician or the MPOA that homecare would not follow. She said the nurse should have called the physician to notify them.She said she did not find out until the afternoon on Friday 2/19/21, and she does not work the weekends. The SSD said the resident discharged home without homecare, even though the discharge paperwork given to the resident documented home care had been set up and would start 2/22/21. The director of nursing (DON) was interviewed on 3/22/21 at 2:31 p.m. The DON said on discharge the nurse reviewed the medications and orders with the resident and completed the nursing section of the discharge summary. She reviewed the discharge paperwork for Resident #137, and said she was not aware the resident was discharged without instructions for nectar thick liquids or the MBSS. She said he was at risk for aspiration. The DON said she was not notified by the SSD, that homecare would not follow him to his brother's house and that he had been discharged home without homecare. 43909 III. Resident #121 A. Resident status Resident #121, age 80, was admitted to the facility on [DATE] and discharged to a different facility on 3/2/21. She began receiving hospice services on 1/27/21. According to the March 2021 computerized physician's orders (CPOs) diagnoses included Parkinson's disease, dementia with Lewy bodies, Alzheimer's disease and disorientation, unspecified. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/9/21 minimum data assessment (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. She required extensive assistance and one person physical assistance with bed mobility, transfers, toileting, dressing, eating, personal hygiene, and dressing. The MDS assessment revealed there was not an active discharge plan in place for the resident to return to the community. It also revealed that the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. The MDS assessment did not identify any behavioral concerns for Resident #121. B. Record review The comprehensive care plan, last reviewed 2/19/21, failed to document any information regarding a plan for the resident to discharge. The care plan did not identify any behavioral concerns for Resident #121. C. Family interview Resident #121's power of attorney (POA) was interviewed on 3/17/21 at 6:16 p.m. The POA said she received a call the morning of 3/1/21 from the hospice social worker (HSW) who suggested that the resident transfer to in-patient hospice for a few days due to a fall the resident suffered on 2/28/21. The POA said she felt it would cause the resident too much distress to move to in-patient hospice for only a few days just to go back to the facility. She said they were private pay and could not afford to keep the resident on in-patient hospice care for longer than the two days. She said after she declined the offer for in-patient hospice, the HSW called her back a few minutes later and told her the facility social services director (SSD) said the resident needed to be discharged from the facility within 72 hours. The POA said she did not receive a phone call or any paperwork regarding the need to discharge the resident in 72 hours. She said she was not given a reason why the resident needed to be discharged and was not made aware of appeal rights. The POA said she had to research and call facilities on her own after she was told about the discharge. She was able to find a facility that accepted the resident within 72 hours and made arrangements for the transfer on 3/2/21. She said she felt extremely distressed and overwhelmed by the discharge process and felt that the resident's discharge was not appropriately initiated or handled by the facility. D. HSW interview The HSW was interviewed on 3/18/21 at 12:40 p.m. The HSW said she went to the facility on [DATE] for a routine visit with Resident #121. She said that during this visit she was notified by the facility nursing home administrator (NHA) that Resident #121's POA had expressed interest in finding a different placement for the resident. The HSW said she called the POA to discuss this, but the POA voiced that she wanted to keep the resident at the facility and was not interested in in-patient hospice. (continued on next page)

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Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The HSW said she called the facility social services director (SSD) to let her know that the POA wanted the resident to remain at the facility and was not interested in discharging at that time. The HSW said the SSD then told her that the resident needed to discharge from the facility because the facility felt that they were not a good fit for the resident and the family. The HSW said the SSD indicated that the facility had been having issues with the POA showing up to the facility without notice because the POA was frustrated about the visitation policy. The HSW said she was told by the SSD that the resident needed to discharge in 72 hours. The HSW said she did not receive any paperwork regarding the discharge. E. Facility staff interview The SSD and NHA were interviewed together on 3/18/21 at 2:45 p.m. The SSD said the POA had indicated in February 2021 that she was interested in moving the resident to a facility closer to her. The SSD said she had sent referrals to a few facilities, however, the facilities had declined to accept the resident. The SSD said the POA decided to discharge the resident on 3/2/21 because a different facility had accepted the resident. The NHA said the POA was upset on the day of discharge due to the fall the resident had suffered a few days prior. The NHA said the POA wanted to visit the resident every day for compassion visits and the facility had struggled to educate the POA on guidelines and limitations for compassion visits. The NHA said that the hospice team felt the resident was ready for in-patient hospice care after the fall, but the POA had declined that option. The NHA said the facility may have said it could take 72 hours for the resident to find a new placement, but not that the resident needed to leave the facility within 72 hours.

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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** 20287 Based on observations, record review and interviews the facility failed to provide person centered care for four (#62, #123, #67 and #82) of five residents reviewed.The facility failed to ensure treatment and care in accordance with professional standards of practice.The residents did not receive quality of care for appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to: -Ensure Resident #82 received timely meal assistance; -Ensure Resident #62 and #67 received grooming assistance; and, -Ensure Resident #123 received nail care. Findings include: I. Facility policy and procedure The Welcome Packet, revised on 1/1/21 with admission kit addendum, was received via email, by nursing home administrator (NHA) on 3/11/21. It read in pertinent part to, Items or services included in nursing home benefits include: routine personal hygiene items and services required to meet the needs of the resident (hair hygiene supplies, comb, brush, bath soap, disinfecting soaps, towels, wash cloths, hospital gowns, hair and nail hygiene services, bathing assistance, and basic personal laundry. II. Resident #82 A. Resident status Resident #82, age 74, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO) diagnoses included, chronic obstructive pulmonary disease, and Alzheimer's disease. The 1/21/21 minimum data set (MDS) assessment showed the resident was unable to complete the interview for a brief interview for mental status (BIMS) score and showed long and short term memory deficits. The resident required extensive assistance with activities of daily living. She required encouragement with eating. The resident resided on the secured unit. B. Observations On 3/11/21 1:10 p.m., the resident received her meal. She was observed to sit at a over bed table in the dining room. She was observed to sit at the table for approximately five minutes, before getting up from the table. The resident did not receive any assistance or encouragement to eat her meal. 3/17/21 Noon meal (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:13 p.m., the resident was sitting at a table in the hallway. -At 12:18 p.m., the resident continued to wait for her meal. -At 12:23 p.m., the resident received her tray and she was eating with a knife. She only received a plastic up of 240 cc of punch, otherwise she received no other beverages, including the eight ounces of milk which the menu directed. -At 12:26 p.m., the unit manager switched the knife with a fork. -At 12:36 p.m., the resident got up and left the table she drank 240 cc of the punch. She only ate a few bites of the potatoes, the cake and half of the ice cream. and a bite of the bun, otherwise that was it. The tray was removed at 12:37. The resident received no encouragement and no alternatives were offered. C. Record review The care plan last updated on 6/8/2020 identified the resident was at risk for decreased ability to perform activities of daily living which included eating. The pertinent approach was to encourage the resident to eat in the dining room. D. Interviews The licensed practical nurse (LPN) #3 was interviewed on 3/18/21 at approximately 4:00 p.m. The LPN said the resident did require encouragement to eat. She said that she was always wandering around the unit. She said at times she became upset when offered assistance, however, should be offered the assistance at each meal. The registered dietitian was interviewed on 3/23/21 at 11:07 a.m. The RD said the resident had experienced a weight loss. She said that the resident was on hospice and that it was an anticipated weight loss. She said the resident required encouragement to eat. 43134 III. Resident #67 A. Resident status Resident #67, age 85, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), the diagnoses included congestive heart failure, vascular dementia, atrial fibrillation, acute respiratory failure with hypoxia, generalized muscle weakness and need for assistance with personal care. The 1/14/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status score of six out of 15. He required limited one person physical assistance with transfers, dressing, toilet use, personal hygiene and supervision with limited assistance with bed mobility and supervision set up assistance with eating. The MDS assessments were incomplete for the C section for communication with the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B.Observations and interviews On 3/16/21 at 11:15 a.m. Resident #67 sat in his wheelchair as he faced the door. He said he had to go to the hospital because his nose was bleeding, and came back soon after that morning. He wore sweatpants that were grey, loose fitted and he pointed out the blood drops on them. On 3/17/21 at 3:00 p.m. Resident #67 wore sweatpants described as the day before and stated that he had not been offered assistance to change them. Resident #67 remained in the clothes he had a nose bleed in, went to the hospital and wore them through two nights and had a shower recorded on 3/18/21. C. Record review The 2/3/21 care plan revealed the resident required assistance with ADL cares (activities of daily living) with bathing, personal hygiene and toileting. The interventions were to monitor for health conditions that contributed to or in general ADL decline. D. Staff interviews CNA #8 was interviewed on 3/17/21 at 2:00 p.m. She stated that Resident #67 needed physical help from a person to help with getting dressed and going to the bathroom. She said the resident went to the hospital and returned later that morning. She said she could not provide the care the residents needed because there were too many residents assigned to each CNA (cross-reference F725, sufficient staff). IV. Resident #123 A.Resident status Resident #123, age 65, was admitted on [DATE] and discharged to hospital 3/15/21. According to the March 2021 computerized physician orders (CPO), the diagnoses included weakness, repeated falls, depression, anxiety, hypotension, muscle weakness, deep vein thrombosis (blood clot), Pulmonary Embolism (blood clot in the lungs), esophagitis with stenosis (narrowing). The 2/23/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with mild impairment with a brief interview for mental status score of 11 out of 15. She required two person physical extensive assistance with mobility, transfers, toilet use and one person limited assistance with dressing and personal hygiene. She had fallen four days after she was admitted . She was taking blood thinning medication. B.Observations and interviews On 3/11/21 at 9:30 a.m. Resident #123 reached out to grab her French toast off the plate and put it in her mouth with her hands. Her fingernails were two or three millimeters long with a large amount of black substance under them. She said she needed someone to take the lids off the tops of her foods because she was not physically able to. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The 2/18/21 care plan, last revised on 3/12/21, read Resident #123 required assistance and was dependent for ADL care in bathing, personal hygiene, eating, mobility, transfers and toileting related to recent illness, repeated falls, fatigue, Impaired balance, dizziness, and limited mobility. She preferred to have a shower at least two times a week. Interventions included to monitor for ADL function decline, evaluate, medicate for pain as appropriate prior to activity. The bathing and shower task documented for dates from 2/22/21 until 3/22/21 for Resident #123 read that the resident refused shower one time, otherwise, there was documentation that the resident only received a shower in 30 days. 41172 IV. Resident #62 A. Resident status Resident #62, age 73, was admitted on [DATE]. According to the March 2021, computerized physician orders (CPO) pertinent diagnoses included, diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart failure and generalized muscle weakness with reduced mobility. The 2/25/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing and toileting. She required extensive one person assistance with personal hygiene. B. Observations On 3/22/21 at 10:47 a.m., Resident #62 was observed in her room in her wheelchair. She had long black and grey hairs extending across her entire upper lip and covering most of her chin. On 3/23/21 at 9:32 a.m., Resident #62 was observed in her room in her wheelchair. She had long black and grey hairs extending across her entire upper lip and covering most of her chin. C. Interviews Licensed practical nurse (LPN) #1 was interviewed on 3/23/21 at 9:32 a.m. She said Resident #62's whiskers were long and needed to be shaved. She said she should have been shaved when the CNA did her shower that morning. She was not sure why the resident had not been shaved. She said to check with the certified nurse aide (CNA). Nurse aide (NA) #4 was interviewed on 3/23/21 at 9:34 a.m. She said she had showered Resident #62 that morning. She said Resident #62's upper lip and chin hairs were long, and she should have shaved her, but she did not. NA #4 said she was the only aide for 18 residents that morning, and she did not have time to shave her (cross-reference F725, sufficient nursing staff). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 3/23/21 at 3:22 p.m. She said the resident should have been shaved with her shower.

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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 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** 43909 Based on observations, interviews and record review, the facility failed to ensure two (#103 and #60) of six residents reviewed for activities of 62 sample residents received an ongoing program of activities designed to meet their individual needs and interests. Specifically, the facility failed to provide meaningful activities based on the resident's preferences to meet and support the physical, mental and psychosocial well-being for Resident #103 and #60. Findings include: I. Resident #103 A. Resident status Resident #103, over age 90, was originally admitted on [DATE] and readmitted on [DATE]. According to the March 2021 computerized physician ' s orders (CPOs) diagnoses included dementia without behavioral disturbance, chronic kidney disease, and encephalopathy (brain disease). The 2/4/21 minimum data assessment (MDS) assessment revealed the resident had severe cognitive impairment and was unable to complete a brief interview for mental status (BIMS). She required extensive assistance and two person physical assistance with all activities of daily living. The preferences for customary routine and activity assessment from the 2/4/21 MDS revealed from interview with the family that the resident felt it was somewhat important to have books, newspapers, and magazines to read, listen to preferred music, be around animals, do things with groups of people, and do her favorite activities. The assessment revealed it was very important for the resident to go outside when the weather was good and participate in religious services. The assessment revealed it was not important at all for the resident to keep up with the news. B. Resident observation On 3/10/21 at 11:24 a.m. the resident was observed seated in her wheelchair in her room facing her television. The activities director (AD) entered the room and said hello to the resident. The resident did not verbally respond or look at the AD. The AD then left the room. On 3/11/21 at 8:42 a.m. the resident was observed seated in her wheelchair in her room facing her television, which had a children ' s TV show on. She had a blanket covering her body up to her neck and a stuffed animal toy on her lap. She was watching the television. At 9:30 a.m. the resident was still seated in front of the TV with a children ' s show playing. At 11:16 a.m. the resident was still seated in front of the TV with a children ' s show playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:00 p.m. the resident was observed being brought back to her room by staff after eating lunch in the dining room. Staff positioned the resident ' s wheelchair to face the TV, which was still playing children ' s programming. On 3/16/21 at 10:58 a.m. the resident was observed seated in her wheelchair in her room facing her television. A children ' s TV show was playing. The resident was not watching the TV. She was observed chewing on her fingernails. At 11:31 a.m. the resident was observed still in her room with a children ' s show playing on the TV and she was fidgeting with her hands. At 3:18 p.m. the resident was observed sleeping in bed. On 3/17/21 at 9:04 a.m. the resident was observed in her room seated in her wheelchair holding a stuffed animal toy. She was watching TV, which was playing children ' s programming. At 10:37 a.m. the AD and additional activity staff entered the hallway with a snack cart which contained cookies, green beaded necklaces, and was playing [NAME] music for the Saint [NAME] ' s Day holiday. The AD entered the resident ' s room and provided her with a green bead necklace and a cookie. At 2:18 p.m. the resident was observed sleeping in bed. C. Record review The activity section of the comprehensive care plan, last revised 2/9/21, revealed the resident enjoyed watching TV/movies in the past, she had a TV in her room, she enjoyed crossword puzzles, music, pet visits, and socializing with others. Activity interventions had not been added or revised in the care plan since 3/25/2020. The 2/4/21 recreation comprehensive assessment summary revealed the resident had moved off the secured unit and was adjusting well to her new room. It revealed that due to COVID-19 restrictions, the resident received individualized visit/1:1 activity offerings from staff daily for socialization, sensory stimulation and to offer leisure materials. It revealed that the resident was active during activity with some cuing and encouragement, and that when in her room, the resident liked watching TV, reading/looking at magazines and fiddling with the busy/fidget blanket. The AD provided Resident #103 ' s activity participation records on 3/18/21 at 3:53 p.m. Review of the participation records revealed in March 2021, the resident actively participated in current events/news/mail activities every day, actively participated in leadership/learning/outreach activities every day, refused bingo when it was offered, and independently participated in movies/TV, relaxing/looking out the window/resting/thinking, and socializing visits every day. D. Staff interviews (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD was interviewed on 3/18/21 at 1:21 p.m. The AD said that activity care plans were updated and reviewed quarterly, annually, and when a significant change of condition occurred. She said the activity programming for Resident #103 consisted of staff reading her the daily chronicles, offering her snacks, and providing lotion and massage to her hands. The AD said the resident liked to watch TV and prior to COVID-19 restrictions, the resident would attend entertainment or music activities as well as pet visits. The AD said the resident ' s family said the resident liked old movies and the AD said she had seen the resident show interest in children ' s shows. Non-certified nurse aide #3 (NA #3) was interviewed on 3/22/21 at 2:37 p.m. NA #3 said Resident #103 was not capable of playing bingo and did not believe the resident would have been able to participate in games or cognitive activities. NA #3 said the resident would verbally respond to staff at times, but not always. NA #3 did not recall seeing the resident participate in activity programming and said she spent most of the day in her room with the TV on and a stuffed animal on her lap. She said the resident loved her stuffed animals and would frequently fidget and move her hands. NA #3 said she felt it would have been helpful for the resident to have a fidget blanket but had not seen her with one before. The AD was interviewed again on 3/22/21 at 5:09 p.m. The AD verified that Resident #103 did not have a fidget blanket or magazines in her room at the time of interview. The AD said it was possible that the fidget blanket was in the laundry. She said she would immediately find some picture magazines for the resident and look for the fidget blanket. The AD said it was inappropriate for activity staff to invite the resident to bingo when that was not one of her preferred activities and she was unable to participate effectively in that type of activity. She said staff should have documented when they were providing lotion to the resident ' s arms on the activity participation records and verified that it had not been marked in January through March 2021. The AD also verified that watching children ' s programming was not identified as one of the resident ' s interests or preferences in prior activity assessments or on the care plan. 20287 II. Resident #60 A. Resident status Resident #60, age younger than 70, was admitted on [DATE], and readmitted on [DATE]. According to the March 2021 CPO, diagnoses included personal history of other (healed) physical injury and trauma, quadriplegia, contracture of muscle, multiple sites, and muscle wasting and atrophy, not elsewhere classified, multiple sites. The 3/15/21 MDS assessment revealed that the resident had cognitive impairments and his cognitive skills for daily decision making were severely impaired, based on the staff assessment for mental status. He required two-person extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/3/2020 MDS assessment revealed that it was very important to the resident to listen to music he liked. It was somewhat important to him to be around animals such as pets, to do things with groups of people, and to go outside to get fresh air when the weather was good. It was not important at all to the resident to have books, newspapers, and magazines to read, to keep up with the news, or to participate in religious services or practices. It was important to him to do his favorite activities, but he couldn ' t do them or had no choice. B. Observations On 3/10/21 at 12:10 p.m., Resident #60 was observed sitting in his wheelchair in the doorway of his room. The television (TV) was on in his room, however, he was unable to see the TV. The resident smiled when he was spoken to. He was unable to converse. On 3/10/21 at 4:48 p.m., the resident was observed lying in bed. There was music playing in his room, however, there were no other meaningful activities observed in the room. On 311/21 at 1:56 p.m., Resident #60 was again observed lying in bed. He was facing the wall. There was music playing in the room, however, there were no tactile touch or any other meaningful activities observed ithe room. On 3/17/21 at 2:30 p.m., the resident was observed lying in bed with his eyes open. The TV was on and playing country music. There was a stuffed animal observed on the floor of the room. On 3/22/21 at 5:04 p.m., Resident #60 was again observed lying in bed with his eyes open. There was music playing in his room, however, there were no other meaningful activities observed in the room. C. Record review Review of Resident #60's activity care plan, initiated on 2/5/18, and revised on 3/22/21, during the survey, revealed the resident enjoyed bingo, music, visiting with family daily, and socializing with others. Pertinent interventions included staff offering/providing individualized visits/one to one activity daily during COVID-19 and as needed for socialization and sensory stimulation, encouraging and facilitating his activity preferences such as music, bingo and socializing with others, listening to his music preference of rap music, and accommodating the resident for cognitive limitations by using single step activities and verbal prompts. The Recreation Quarterly Progress Note and Evaluation assessment completed on 8/27/2020 documented the resident pursued independent leisure activities such as watching television (TV), listening to music, and socializing with others. He continued to receive individualized visits/one to one activity offerings from staff daily, participated in exercise, learning, current events with staff reading to him, enjoyed the socials/socializing with staff daily, participated in zoom calls with family weekly, and he had no activity issues. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Recreation Quarterly Progress Note and Evaluation assessment completed on 3/15/21 documented the resident pursued independent leisure activities such as watching TV, listening to music, and socializing with others. He continued to receive individualized visits/one to one activity offerings from staff daily,was active during activity with staff reading daily chronicles and facts for him, liked to exercise with staff (arm/hand raise, leg raise and sit ups (upper body movement) and socialize with staff, and participated in zoom calls with family weekly. D. Staff Interviews The wound care nurse (WCN), who was also the unit manager for the 800 hallway, was interviewed on 3/23/21 at 1:19 p.m. The WCN said Resident #60 spent the majority of time in his bed. She said that when residents were admitted , their preferences were reviewed. She said the resident did not play video games. She said to her knowledge the facility did not have video games. Licensed practical nurse (LPN) #1 was interviewed on 3/23/21 at 2:00 p.m. LPN #1 said she was familiar with Resident #60 when he lived on the 100 hallway. She said that he used to receive daily visits from his mother, and always enjoyed sitting outside. The activity director (AD) was interviewed on 3/22/21 at 5:28 p.m. The AD said the resident was not on a one to one program. She said someone from the activity department stopped in and saw him daily. She said he had music playing in his room and also had the TV on. She said she thought his socialization needs were being met on his level. She said he liked to socialize with people his age, so one of the activity assistants who was similar in age to the resident was often the person who provided those visits. She said the resident would smile when he was spoken to. The AD said the resident benefited from touch stimulation and tactile items. She said the facility used stuffed animals to meet that need. The AD said that she did not have any evening activities which were conducted by the activity staff. She said that she expected the certified nurse aides (CNA) to assist with evening activities. She said the activity program at the facility did not include programs which were directed toward a younger population. The social services director (SSD) was interviewed on 3/23/21 at 1:45 p.m. The SSD said Resident #60 liked music and the outdoors. She said that he was unable to communicate verbally. She said he enjoyed video games, but was unable to play them. She said he had posters hanging in his original room. She said when he lived on the 100 hallway he had more activities to do.

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	065415	A. Building B. Wing	03/23/2021

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43134 Based on record review, observations and family and staff interviews, the facility failed to ensure five (#63, #62, #79, #123 and #71) residents out of 62 sample residents received treatment and services necessary in accordance with professional standards of practice. Specifically: Resident #123, who was receiving anticoagulant medication, was found on the floor after an unwitnessed fall on [DATE] at 1:40 p.m. (Cross-reference F689) The facility failed to accurately and timely document and monitor Resident #123's neurological status after the fall, as well as, signs and symptoms of bleeding. An initial assessment by a registered nurse (RN) was followed by an assessment by a licensed practical nurse (LPN) 41 minutes later. At that time, the resident had an altered mental status with signs of increased confusion and lethargy. There was no documentation of further monitoring. A transfer note read she was sent to the hospital on [DATE] at 6:00 p.m. with progression of lethargy, confusion and unclear speech. Hospital records revealed the resident developed a hematoma inside her body with a slow bleed. The hematoma from the fall was inoperable and she passed away on [DATE]. In addition, the facility failed to ensure Residents #79 and #71, on anticoagulant therapy, were monitored for signs and symptoms of bleeding, that physician orders and were followed for Residents #62 and that a follow up appointment was scheduled for Resident #63. Findings include: I. Failure to monitor resident status after unwitnessed fall A. Professional reference The Agency for Health Care Research and Quality article Fall Response, [DATE], read in pertinent part: Residents should have increased monitoring for the first 72 hours after a fall. Each shift, the nurse should record in the medical record a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented in the nurse's note. Retrieved [DATE] from https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man2.html B. Resident #123 1. Resident Status Resident #123, age 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included weakness, repeated falls, depression, anxiety, hypotension, muscle weakness, deep vein thrombosis (blood clot), pulmonary embolism (blood clot in the lungs), esophagitis with stenosis (swelling and narrowing of the esophagus). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The [DATE] minimum data set (MDS) assessment revealed the resident was moderately cognitively intact wild impairment with a brief interview for mental status score of 11 out of 15. She required two-person physical extensive assistance with mobility, transfers, toilet use and one person limited assistance with dressing and personal hygiene. She had fallen four days after she was admitted . She was taking anticoagulant medication (blood thinning medication). She did not use supplemental oxygen. Resident #123 was interviewed on [DATE] at 9:30 a.m. She was alert and spoke clearly and purposefully while she explained the issues she faced. She said she required more assistance with transfers and meals set up to eat than she received. She stated, I need help with a lot of things, like getting into my wheelchair, going to the bathroom. She said she required assistance with transferring to her wheelchair and toileting. She used a wheelchair to move about in her room and in the facility. As she pointed to her bowl of oatmeal with the lid on it beside her on the bedside table, she said, I have been waiting to get help taking this lid off. I am so weak right lately and I need to eat. She said the doctor had told her she was malnourished and needed to eat better. The resident's care plan, dated [DATE], revealed Resident #123 had a high risk of injury related to anticoagulation therapy with the goal for the resident not to have signs or symptoms of bleeding. The care plan did not direct staff what signs of bleeding to monitor the resident for or direct staff to document indications of abnormal bleeding. 2. Fall [DATE] and resident decline On [DATE] at 1:40 p.m., a nursing progress note stated a certified nurse aide (CNA) alerted registered nurse (RN) #1 that Resident #123 was found on the floor. A mechanical lift was used to assist the resident into bed. RN #1 performed an initial assessment. The resident's vital signs revealed her oxygen saturation was low and oxygen was administered per physician orders. On [DATE] at 2:21 p.m. (41 minutes after the RN's initial assessment), LPN #4 completed a change in condition because the resident had increased confusion; Resident #123 was responding with slurred speech and the LPN was unable to comprehend what the resident was saying. It was noted the resident was on an anticoagulant medication. A note at 2:28 p.m. read the resident was lethargic and drowsy. A pain assessment was conducted without a response from the resident. There was no further monitoring of the resident's neurological or physical status until a progress note read on [DATE] at 7:13 p.m. that read, hospital. A [DATE] facility to hospital transfer form, dated at 6:00 p.m., revealed the resident was transported to the hospital per a physician order for further evaluation due to an altered mental status with drowsiness, confusion and unclear speech. The transfer form read the resident's vital signs were different from her usual numbers with increased heart rate, lower blood pressure and lower oxygen saturation with oxygen delivery with a nasal cannula. The [DATE] hospital records, provided by the DON on [DATE] at 4:00 p.m., revealed Resident #123 arrived at the hospital non responsive except to touch with eye movement and incoherent words. The [DATE] computed tomography scan (CT scan) revealed she had a hematoma (pocket of blood inside the body) with a slow bleed. The injury was inoperable because of her frail state and she was transferred to an inpatient hospice unit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #123's daughter was interviewed on [DATE] at 9:30 a.m. She said Resident #123's spouse was notified of the resident's fall on [DATE]. On [DATE], they were notified at 6:00 p.m. that the resident had been transferred to the hospital and they met her at the emergency department. She said Resident #123 was unresponsive when they saw her at about 9:30 p.m. The doctors had discussed that the treatment for the hematoma with a small bleed in her body would need surgery. However, the family was informed the resident was in a more fragile state because she suffered a large blood loss, and hospice would be a better option. The daughter said Resident #123 began hospice care and died on [DATE] as a result from the fall with the injury. The DON was interviewed on [DATE] at 6:00 p.m. She said she was updated that Resident #123 admitted to the hospital on [DATE] because of swelling and bleeding found in her esophagus. The assistant director of nursing (ADON) was interviewed on [DATE] at 2:50 p.m. He said he noticed a change in Resident #123's cognition on [DATE]; the resident was able to speak to him in a conversation and then later in the afternoon she sounded different and was sent to the hospital for altered mental status. 3. Facility failures a. The facility did not accurately document or monitor Resident #123's neurological status for an unwitnessed fall per standards of practice. The DON and the Senior Rapid Response Coordinator (SRRM) were interviewed on [DATE] at 6:10 p.m. The DON stated the standard of practice for residents with an unwitnessed fall was that the resident needed documented monitoring for a minimum of 72 hours after an unwitnessed fall or if the resident hit their head during a fall. RN #1 was interviewed on [DATE] at 3:00 p.m. She stated she covered for LPN #4 while she went to lunch break and was the nurse who performed the initial assessment of the resident. She said at that time, Resident #123 appeared to be alert and oriented and did not have any notable injuries. She said that she completed an initial assessment and began neuro checks (neurological assessment and monitoring), then gave a report to the resident's primary nurse, LPN #4. She said she was not asked to re-evaluate the resident by the resident's primary nurse. No record of neurological monitoring after Resident #123's fall and RN #1 initial assessment on [DATE] was found in her record. On [DATE] at 11:00 a.m., the [DATE] post fall neurological monitoring of Resident #123 was requested from the nursing home administrator (NHA). It was not provided. On [DATE] at 11:15 a.m., the post fall neurological monitoring was requested from the director of nursing (DON). It was not provided. On [DATE] at 6:15 p.m., a follow up for the requested neurological monitoring for Resident #123 was requested from the DON a second time. It was received with the same information as documented in the progress notes and the transfer form. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. The facility failed to monitor Resident #123 for signs and symptoms of abnormal bleeding while the resident was taking an anticoagulation medication. CNA #5 was interviewed on [DATE] at 2:00 p.m. She stated the resident had blood when she had bowel movements. It had happened a couple days and she told RN #3 what she saw. However, there was no documentation of this in the resident's record and further review of the resident's progress notes from her admission to [DATE] revealed no documentation the resident was monitored for abnormal bleeding either routinely or after her fall [DATE]. The DON was interviewed on [DATE] at 5:40 p.m. She said anticoagulation therapy was monitored when a resident was admitted to the facility, began or changed anticoagulant medications. Documented monitoring for resident's signs and symptoms of bleeding was revised or began on [DATE] (during survey) with corrected orders done by her for more accurate monitoring. 20287 II. Failure to monitor for signs/symptoms of bleeding while on an anticoagulant/antiplatelet medication A. Resident #71 1. Resident status Resident #71, age younger than 70, was admitted on [DATE], and readmitted on [DATE]. According to the [DATE] CPO, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, unspecified sequelae of unspecified cerebrovascular disease, and long term (current) use of anticoagulant. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS of 15 out of 15. The resident required two-person extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. He required the use of an anticoagulant medication. 2. Record review Review of Resident # 71's [DATE] CPO revealed a physician's order for Plavix tablet 75 milligrams (mg). Give 75 mg via percutaneous endoscopic gastrostomy (PEG) tube one time a day. The order had a start date of [DATE]. There was not a physician's order to monitor the resident for signs and symptoms of bleeding. 3. Facility follow up On [DATE], during the survey, the facility obtained a physician's order to monitor Resident #71 for signs and symptoms of bleeding. See DON interview above. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	B. Resident #79 1. Resident status Resident #79, age 83, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, Takotsubo syndrome, acute on chronic diastolic (congestive) heart failure, myocardial infarction type 2, and cerebral infarction due to thrombosis left posterior cerebral artery. The [DATE] MDS assessment revealed that the resident had moderate cognitive impairment with a BIMS of 11 out of 15. The resident required one-person limited assistance with bed mobility, transfers, dressing, and toilet use. She required one-person extensive assistance with personal hygiene. 2. Record review Review of Resident # 79's [DATE] CPO revealed a physician's order for Plavix tablet 75 mg. Give 75 mg by mouth one time a day for stroke prevention. The order had a start date of [DATE]. There was not a physician's order to monitor the resident for signs and symptoms of bleeding. Review of Resident #79's comprehensive care plan revealed the resident did not have a care plan to monitor for signs and symptoms of bleeding related to the use of an antiplatelet or anticoagulation medication. See DON interview above. 41172 III. Failure to follow physician orders A. Facility policy and procedure The Medication Administration policy, revised [DATE], was received from the DON on [DATE] at 4:45 p.m. The policy documented in pertinent part, administer medication, monitor patients for adverse reactions and effectiveness of medication. B. Resident #62 1. Resident status Resident #62, age 73, was admitted on [DATE]. According to the [DATE], computerized physician orders (CPO) pertinent diagnoses included, diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart failure, and chronic kidney disease stage three. The [DATE] MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of 6 out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing and toileting. She required extensive one person assistance with personal hygiene. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Record review The physician's orders and medication administration records (MARs) for [DATE] through [DATE] were reviewed. The following was documented: -On [DATE], Metoprolol Tartrate Tablet 75 mg (milligrams), give 75 mg one time a day for hypertension. Hold if the systolic blood pressure was less than 110 mmhg (millimeters mercury) or pulse less than 60 beats per minute. The order was discontinued on [DATE]. There were no documented blood pressure or pulse checks prior to administration of the medication from [DATE] through [DATE]. -On [DATE], Metoprolol Tartrate Tablet 50 mg (milligrams), give 75 mg two times a day for hypertension. Hold if the systolic blood pressure was less than 110 mmhg (millimeters mercury) or pulse less than 60 beats per minute. On [DATE], the resident's blood pressure was documented as ,d+[DATE], there was no pulse documented. There were no further blood pressure or pulse checks documented prior to the administration of the medication, from [DATE] through [DATE]. - On [DATE], Amlodipine Besylate tablet, 10 mg, give 10 mg by mouth one time a day for hypertension and congestive heart failure (CHF). Hold if the systolic blood pressure was less than 110 mmhg. The order discontinued on [DATE]. There were no blood pressure checks documented prior to the administration of the medication from [DATE] to [DATE]. -On [DATE], Amlodipine Besylate tablet, 5 mg, give 10 mg by mouth one time a day for hypertension and congestive heart failure (CHF). Hold if the systolic blood pressure was less than 110 mmHg. There were no blood pressure checks documented prior to the administration of the medication from [DATE] to [DATE]. -Furosemide tablet 20 mg, give 20 mg by mouth one time a day for CHF. Hold if the systolic blood pressure was less than 110 mmhg (millimeters mercury) or pulse less than 60 beats per minute. There were no blood pressure or pulse checks documented prior to the administration of the medication from [DATE] to [DATE]. The vital signs and weights tab documentation in the electronic medical record (EMR) was reviewed. There were no blood pressure or pulse checks documented directly before the administration of the medications. 3. Interviews LPN #5 was interviewed on [DATE] at 10:02 a.m. She reviewed the orders on the MAR for Resident #62. She said, I cannot find where the blood pressure and pulse were documented before the medications were given. LPN #5 said the blood pressure and pulse should be checked and documented before the administration of the medication. She said the medication should be held per the physician's orders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The assistant director of nursing (ADON) was interviewed on [DATE] at 11:01 a.m. He said the blood pressure and pulse should have been checked before giving the medication per the physician's order. He reviewed the electronic medical record (EMR) and MAR. He said he could not locate where the vital signs had been documented prior to the administration of the medication. He said normally there was an attached area to document the vital signs if there was an ordered parameter to hold the mediation. The ADON said he would complete a medication error report and investigate the situation. The ADON said he would notify the DON for follow up. The DON was interviewed on [DATE] at 3:31 p.m. She said a medication error would be completed and the physician and family would be notified. She said the person who transcribed the order did not add an area for the vital signs to be documented. She said, regardless, the order told the nurse to check the blood pressure and/or pulse and this was not done. 4. Facility follow up The DON was interviewed again on [DATE] at 12:40 p.m. She said an area had been added to the MAR to document the vital signs as ordered. She said the physician had been notified. The DON said she reviewed other residents' records for similar concerns for those on cardiac medications. The DON said she had educated the nurse on entering orders into the computer system when a parameter was ordered. The DON said she did not inservice the nurses on taking time to read the actual order which documented to check the blood pressure and/or pulse before administering, and holding the medication according to the parameter. The inservice sign in sheet dated [DATE] was reviewed. The presenter was Nursing. There were 14 signatures. The form documented When entering cardiac medication and parameters are given. Supplement documentation needs to be added (BP, HR). If medication is given outside the parameters it is considered a medication error. IV. Failure to schedule follow up appointment Resident #63 A. Resident status Resident #63, age 80, was admitted on [DATE]. According to the [DATE]CPO, pertinent diagnoses included cerebral infarction (stroke), diabetes mellitus, encephalopathy, dysphagia, dementia, and gastrostomy tube. The [DATE] MDS assessment did not document a BIMS score. His long and short term memory was not documented. The MDS documented he was aphasic (unable to understand speech) and had dementia. He required extensive assistance of two persons with bed mobility, transfers, dressing, toileting, and personal hygiene. He was extensive one person assistance with eating, and he had a feeding tube. B. Record review The physician's orders for [DATE] were reviewed. Resident #63 had an order dated [DATE] that read: Okay to administer tube feeding, water and medications through G-tube with perforation sealed with Suresite. Follow up with Gastro for replacement [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:00 p.m., the nurses' notes documented,Resident has a small perforation to g-tube. Unable to visualize however a small amount of leaking was noted. Area was secured with a transparent nonpermeable dressing and secured with medication tape. Gastro was notified, awaiting orders to determine if tube would be safe/effective to use in its current condition or to schedule appt to have it replaced. On [DATE] at 6:58 a.m., the nurses' notes documented the resident pulled out his feeding tube around 6:00 a.m. On [DATE] at 8:37 a.m., the nurses' notes documented the resident was sent out on night shift [DATE] to [DATE] after pulling out his PEG (percutaneous endoscopic gastrostomy) tube and the PEG tube was replaced. C. Interviews RN #4 was interviewed on [DATE] at 12:45 p.m. She said Resident #63 had pulled out his feeding tube last night. She said he was sent to the hospital to have it replaced and returned this morning. RN #4 said she was glad he pulled it out because it had a hole in it for several weeks, and had not been replaced. The unit clerk (UC) was interviewed [DATE] at 4:01 p.m. She said she had called the gastroenterology office on [DATE] and notified the ADON of the need for the appointment. The UC said she had faxed the clinic the requested documentation on [DATE], and called them on [DATE], and left a voice message. She said she did not hear back from them. The UC said she had not followed up with the clinic from [DATE] to [DATE] when the resident pulled out the tube. The DON was interviewed on [DATE] at 12:35 p.m. She said Resident #63 had pulled out his G-tube on [DATE] and it was replaced. She said she would investigate why an appointment with gastroenterology was not scheduled as ordered on [DATE]. The DON was interviewed again on [DATE] at 5:15 p.m. She said the gastroenterology office had been calling the family to schedule the appointment instead of the facility. The DON said the UC should have followed up after [DATE], when she did not hear back, to get an appointment scheduled. She said the UC did not follow up after [DATE]. The medical records coordinator (MRC) was interviewed on [DATE] at 5:00 p.m. She said she called the gastroenterology office today, and scheduled the resident an appointment for [DATE].

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent pressure injuries from occurring and worsening, for three (#62, #103, and #121) of six residents reviewed out of 62 sample residents. Facility failures contributed to Resident #62, an at risk resident, developing avoidable pressure injury to the left heel and worsening pressure injury to the right heel. Specifically, the facility failed to timely identify the resident's wheelchair footrest was inadequate, causing unrelieved pressure to the resident's heels. Moreover, the facility did not notify the responsible party or the primary care physician of the new left heel wound and failed to develop a person-centered care plan for the left heel wound. The facility's failures contributed to Resident #62's prior right heel callus progressing to an unstageable pressure injury and contributed to her developing a new deep tissue injury to the left heel. Additionally, the facility failed to: -Ensure Resident #103, who was at high risk for skin breakdown, did not develop an avoidable pressure injury and an identified water blister was accurately documented; and, -Ensure Resident #121 had interventions in place to prevent the development of a pressure injury, and to keep it from worsening. Findings include: I. Professional reference A. The National Pressure Ulcer Advisory Panel (2016) NPUAP Pressure Injury Stages, retrieved 3/26/21 from:http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages revealed the following pertinent information: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. -An unstageable pressure injury is an injury with obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. -A deep tissue pressure injury (DTPI) is a persistent non-blanchable deep red, maroon or purple discoloration resulting from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	II. Facility policy and procedure The facility's pressure injury policy was requested from the wound care nurse (WCN) on 3/22/21 at 4:40 p.m. , and not received. III. Resident #62 A. Resident status Resident #62, age 73, was admitted on [DATE]. According to the March 2021, computerized physician orders (CPO), pertinent diagnoses included diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart failure and generalized muscle weakness with reduced mobility. The 2/25/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing and toileting. She required extensive one person assistance with personal hygiene. She had two unstageable pressure injuries, one of which was present on admission. B. Record review Right heel, pressure injury unstageable: The admission nurse note dated 12/31/20 was reviewed. The note documented Resident #62 had a dark area surrounded by thick dry callous to the right heel. There was no further description of the callus. The note documented the area as other, not pressure. There was no documentation of a wound to the left heel. The Braden skin risk assessment scale dated 1/14/21 was reviewed. The resident scored 17, and was documented as at risk for skin breakdown. Her risk was partially due to being chairfast with limited mobility, and the potential for shearing. On 1/6/21, six days after the calloused area to the right heel was documented on admission, the wound care notes documented an unstageable pressure injury which measured 3.8 cm (centimeters) by 4.5 centimeters. The depth was unable to be determined. It was documented as 100% eschar (dead tissue). The wound care notes documented on 2/3/21 that the right heel wound was worse. It measured 4.0 by 2.0 cm and the depth was unable to be determined. The wound care notes dated 3/1/21 documented the right heel wound measured 4.5 by 3.0 cm and the depth was unable to be determined. The note documented there was moderate serosanguinous (bloody, watery) drainage and the area around the wound was red. It further documented the resident was on an antibiotic (see below). The wound care note documented the wound was worse. The wound care notes dated 3/22/21, during the survey, read the right heel wound measured 4.0 by 2.2 cm and the depth was 0.1 cm and the wound was again debrided. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The primary physician's notes dated 3/19/21 were reviewed. The physician documented a pressure ulcer to the right heel with an unspecified stage. There was no documentation of a pressure injury to the left heel. The physician orders were reviewed. On 2/21/21, 52 days after the resident was admitted with a callus to her right heel, boots to both feet to prevent skin breakdown were ordered. The physician orders dated 2/24/21 documented Keflex (antibiotic) capsule 500 mg (milligrams) three times a day for cellulitis to the right lower extremity for seven days. The current treatment orders dated 3/3/21 for the right heel included: cleanse with normal saline or wound cleanser, pat area dry, apply Medihoney to heel and cover with abdominal pad, wrap with kerlix every other day and as needed. Left heel, pressure injury deep tissue injury (DTPI): The physician's orders were reviewed. The order dated 3/8/21 documented pressure injury, unstageable to the left heel, cleanse with normal saline or wound cleanser, pat dry, apply sure prep to the left heel daily and as needed. Although it could not be determined which physician (primary care or wound care physician) wrote the order, see primary care physician interview below that he was unaware of the left heel injury. The nurses' notes were reviewed. There were no nursing notes related to the left heel wound on or before 3/8/21, when the physician orders were written. On 3/10/21, the nurses' notes documented, skin check was performed, the following skin injury or wound were previously identified and were evaluated as follows, pressure area, left and right heel. There was no further documentation. There was no documentation the family was notified. The first note provided by the facility regarding the left heel wound was dated 3/15/21. All wound care notes were requested from the WCN. The left heel was not staged or documented as a DTPI on this assessment. The size was documented as 1.7 cm by 2.2 cm area with undetermined depth. The wound care notes documented on 3/22/21 that the left heel wound was a deep tissue injury and measured 1.7 by 2.1 cm with undetermined depth. Care plan The care plan was reviewed. The care plan initiated 1/21/21 documented the resident had actual skin breakdown to the right heel. It documented the right heel had an unstageable pressure injury. There was no care plan for the left heel. -The goal was documented as resident will remain free of skin tears and or bruising throughout the review period. The goal was not to heal or prevent pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The WCN was interviewed again on 3/23/21 at 11:13 a.m. She said the resident's right heel wound was present on admission and the left heel was a deep tissue injury due to her footrests. -She said the footrests were too short and the resident's feet rested on top of the edge of the footrests which caused the wound to the left heel to develop and the right heel wound to worsen. -She said she was notified of the left heel wound on 3/8/21. The WCN said the nurse discovered the wound on 3/8/21 and notified her because that was the day of wound rounds. -She said the nurse should have completed a change of condition and notified the physician and family. However, she said she was unable to locate a change of condition or notification of the family. Resident #62's power of attorney (POA) was interviewed via telephone on 3/23/21 at 1:24 p.m. She said Resident #62 had a chronic callous to the right heel and she frequently applied lotion to when she lived at home. She said she was not notified of a pressure injury to the left heel. The WCN was interviewed again on 3/23/21 at 1:24 p.m. She said therapy was responsible for fitting the resident in the correct wheelchair with footrests on admission. She said Resident #62 should have had daily foot checks because she was a diabetic. The WCN said the diabetic foot checks would have been documented on the TAR. She said it was on the care plan and she did not know why it was not on the TAR. The WCN said there was no care plan for the left heel wound because she had not done it yet. The Director of Rehabilitation (DOR) was interviewed on 3/23/21 at 2:05 p.m. He said the therapy department evaluated new admissions for a wheelchair including footrests. He said Resident #62 was evaluated on 1/6/21 and given a wheelchair and footrests. The DOR said he did not know why or how the footrests would have been too small or short causing the resident's foot to rest on the edge of the footrests. He said he had not been informed of this. The DOR said he would speak to the occupation therapist (OT) who had treated the resident. The OT was interviewed on 3/23/21 at 2:43 p.m. He said he had seen the resident for wheelchair positioning on admission, and her condition declined since then. He said he had assessed her wheelchair and issued standard leg rests on 2/22/21. He said the nursing staff had not notified him that the leg rests were too short or that the resident's feet were resting on the edge of the footrests. He said she had become more rigid and her hips may have not been all the way back in the wheelchair, causing her feet to rest on the footrest edge. The OT said if he had been notified, he could have intervened and possibly added a footrest extender. The OT said he had placed her in a new wheelchair on 3/10/21, after the development of the left heel wound. The director of nursing (DON) was interviewed on 3/23/21 at 3:22 p.m. She said the nurse should have completed a change of condition for the new left heel wound that developed on 3/8/21. She said she should have documented that the family and primary care physician were notified (see physician interview below). The DON said she did not know what the root cause was of the wounds to both heels. She said if the wounds were caused from the wheelchair footrests being too short, the nurse should have notified the OT. She said the nurse could have called them or left them a written message. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The wound care physician was interviewed on 3/23/21 at 6:18 p.m. via telephone. He said the right heel was an unstageable pressure injury. He said he debrided (removal of dead or necrotic skin tissue) the right heel this week. The wound care physician said the left heel was a deep tissue injury (DTPI) from having the heel resting on the edge of the footrest. He said he did not know if it was the angle of the footrest or the height. He said the left heel could open up into a stage 3 or 4 wound. The wound care physician said there was no reason the wounds should not heal if the pressure was relieved. The primary care physician was interviewed via telephone on 3/25/21 at 12:50 p.m. He said he was aware of the pressure injury to the right heel. He said he was not notified of the DTI pressure injury to the left heel. The physician said the resident had no nutritional or vascular concerns and the wounds should heal. D. Observations The wounds were observed on 3/22/21, at 4:11 p.m. with LPN #6. The resident was lying in bed with light blue soft boots to both feet. She grimaced and cried when the nurse removed the boots. She said her heels hurt and the nurse offered her Tylenol. The right heel was covered in gauze and unable to be observed; the nurse had already changed the dressing. The left heel had a wound, dry blister appearing, which was approximately 4 cm, circular, with blood noted in the center approximately 2 cm. There was no dressing on the left heel. 43909 IV. Resident #103 A. Resident status Resident #103, over age 90, was originally admitted on [DATE] and readmitted on [DATE]. According to the March 2021 CPOs, diagnoses included dementia without behavioral disturbance, chronic kidney disease, and encephalopathy (brain disease). The 2/4/21 MDS assessment revealed the resident had severe cognitive impairment and was unable to complete a BIMS. She required extensive assistance and two-person physical assistance with all activities of daily living (ADLs). The MDS revealed the resident was at risk of developing pressure ulcers; however, she had no unhealed pressure ulcers at stage 1 or higher at the time of assessment. B. Record review The skin breakdown section of the comprehensive care plan, last revised 2/23/21, revealed the resident was at risk for skin breakdown related to recent fracture with limited mobility, actual skin breakdown, advanced age, decreased activity, and incontinence. Pertinent interventions included: -Provide preventative skin care (lotions, barrier creams) as ordered, initiated 1/18/19; -Observe skin condition daily with ADL care and report abnormalities, initiated 1/18/19; -Off load/float heels while in bed, initiated 1/18/19; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Lower extremity protectors, initiated 8/24/2020; and, -Upper extremity protectors, initiated 8/24/2020 The 2/4/21 Braden scale for predicting pressure sore risk revealed the resident was at high risk for pressure injuries due to very limited sensory perception, occasionally moist skin, chairfast activity level, very limited mobility, probably inadequate nutrition, and problems with friction and shearing when moving. The 3/1/21 situation, background, assessment and recommendation form (SBAR) revealed a certified nurse aide (CNA) noticed a small pinpoint size water blister on the lower back/left buttocks area of Resident #103 after the resident received a shower. The primary care clinician was notified on 3/1/21 at 3:00 p.m. and recommended to monitor the area and apply healing barrier cream twice daily. The March 2021 CPOs revealed an order, initiated 3/3/21, for moisture barrier cream to be applied twice daily to buttocks after incontinence care for skin protection. Review of the progress notes revealed the following: -3/2/21 nursing documentation note read the resident had an open area on her left lower back, no drainage noted, and barrier cream was applied. -3/3/21 nursing documentation note read the resident had a small red area noted to her left lower back and barrier cream was applied. -3/4/21 nursing documentation note read the resident had redness to the left lower back and barrier cream was applied. -3/5/21 nursing documentation note read the resident had bruising to the left leg and left upper arm. There was no documentation regarding the redness to the left lower back. The 3/7/21 skin check revealed the resident had bruises on her left upper arm and bilateral lower extremity redness with a purple bump to the left leg. The water blister discovered on 3/1/21 was not identified on the 3/7/21 skin check, and no documentation was found to support that the water blister had resolved. C. Staff interview The wound care nurse (WCN) was interviewed on 3/18/21 at 3:30 p.m. The WCN said if a change in the condition of a resident ' s skin was identified, new interventions would be added to the care plan and a change of condition nursing note would be documented every 8 hours regarding the issue for the next 72 hours. If after the first 72 hours the issue got worse, a new change of condition assessment would be completed and the physician would be notified. -The WCN said a skin assessment was completed weekly which would track and monitor the skin injury and indicate if the skin injury was improving, worsening, or the same. She said when a skin issue was identified and triggered a change in condition, it would be documented on the care plan with the correlated interventions in place and the resolved date if it did resolve. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The WCN did not know why Resident #103 ' s skin concern identified on 3/1/21 was not documented on the care plan or if the skin concern was resolved since there was no documentation indicating it was resolved. V. Resident #121 A. Resident status Resident #121, age 80, was admitted to the facility on [DATE] and discharged on [DATE]. She began receiving hospice services on 1/27/21. According to the March 2021 CPOs, diagnoses included Parkinson's disease, dementia with Lewy bodies, Alzheimer's disease, and disorientation, unspecified. The 2/9/21 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of ten out of 15. She required extensive assistance and one person physical assistance with bed mobility, transfers, toileting, dressing, eating, personal hygiene, and dressing. The 2/9/21 MDS assessment also revealed the resident had one unstageable deep tissue injury that was present upon admission; however, the 1/9/21 MDS admission assessment and the 1/3/21 skin check revealed the resident had no unhealed pressure injuries or skin concerns upon admission. B. Record review The skin breakdown section of the comprehensive care plan, last updated 2/4/21, revealed the resident was at risk for skin breakdown related to extremely dry skin to bilateral lower extremities. The goal was for the resident to remain free of skin tears and/or bruising. Pertinent interventions included: -Apply barrier cream with each cleansing, initiated 2/4/21; -Turn and/or reposition and check skin frequently as determined by tissue tolerance, initiated 2/4/21; -Evaluate for any localized skin problems (dryness), initiated 1/3/21; -Observe for verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered, initiated 2/4/21; and, -Weekly wound assessment to include measurements and description of wound status, initiated 2/4/21. Review of the progress notes revealed: -1/9/21 care plan evaluation note read due to her age and fragile skin she is at risk for developing pressure ulcers, and skin checks (have) not identified skin issues post admission. -1/26/21 SBAR revealed an open area one centimeter (cm) in diameter to coccyx and a scratch to the inner left vaginal lip were identified. The physician and the family were notified on 1/26/21 at 7:00 p.m. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-1/31/21 skin check assessment revealed no skin injury/wounds were noted. -2/8/21 skin check assessment revealed a pressure injury to the sacrum -2/15/21 skin check assessment revealed a pressure injury to the sacrum -2/22/21 skin check assessment revealed a pressure injury to the sacrum -2/23/21 general note revealed an air mattress was ordered for the resident and the resident was being seen by the wound care team for rounds due to the wound on her coccyx. The resident was educated about the importance of allowing repositioning to prevent additional pressure to the wound site. The 1/27/21 wound team document revealed the resident had a deep tissue injury to the sacrum which measured 3.5cm by 4cm by 0cm. It had no drainage and was 100% epithelial tissue (light pink in color). The periwound (tissue surrounding the wound) was healthy. The treatment was to apply zinc barrier cream twice daily and provide cushions. The 2/3/21 wound team document revealed the sacrum deep tissue injury had improved and measured 2cm by 1cm by 0cm. It had no drainage and was 100% epithelial tissue. The periwound was described as scaly. The treatment was to apply both zinc barrier cream and silicone barrier cream twice daily. The 2/8/21 wound team document revealed the sacrum deep tissue injury had worsened and measured 5cm by 3cm by 0cm. The wound had minimal serosanguinous (clear fluid with some blood) drainage and was 100% epithelial tissue. The periwound was healthy. The treatment was to apply zinc barrier cream twice daily. The 2/15/21 wound team document revealed the sacrum deep tissue injury had improved and measured 1. 5cm by 4.5cm by 0.2cm. The wound had scant drainage (wound dressings only slightly moist) and was now 100% granulation tissue, which indicated the wound was healing. The periwound was healthy. The treatment was to apply both zinc barrier cream and silicon barrier cream twice daily and as needed. The 2/22/21 wound team document revealed the sacrum injury had changed to a Kennedy ulcer (unavoidable skin breakdown as part of the dying process) which measured 2cm by 5cm by 0.2cm. The wound had moderate serosanguinous drainage and was 90% epithelial tissue and 10% granulation tissue. The periwound was healthy. The treatment remained the same. The notes section of the document revealed the skin worsening was unavoidable due to malnutrition, immobility and incontinence. The 3/1/21 wound team document revealed the sacrum Kennedy ulcer had worsened and measured 5.2cm by 4.8cm by 0.3cm. The wound had minimal drainage and was made of 60% epithelial tissue, 20% granulation tissue, and 20% eschar (dead tissue). The periwound was healthy, though the wound was described as tender. The treatment remained the same. The resident was discharged to a different facility on 3/2/21. C. Facility failures (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	See care plan above; there were no updates or revisions to the resident's care plan past 2/4/21 although her wound worsened leading up to her discharge on 3/2/21. Although educated on the importance of repositioning, there was no direction to staff regarding repositioning in the care plan. Review of the record from 1/26 to 3/1/21 revealed no documentation the resident's power of attorney was notified after it was initially discovered, of the resident's worsening wound. D. Power of attorney interview Resident #121's power of attorney (POA) was interviewed on 3/17/21 at 6:16 p.m. She said the resident had developed a wound on her lower back while at the facility and was put on hospice care on 1/27/21. The POA said the resident had been mobile and used a walker when she first got to the facility. She said her compassion visits had been restricted by the facility mid-February so she had no idea how bad the resident's wound had gotten until she was discharged to the new facility. She said when the resident got to the new facility, the wound was horrific and the resident had such significant diaper rash that her vaginal area was unrecognizable.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review, interviews and observations, the facility failed to ensure that one resident (#63), out of one resident reviewed, received proper treatment and care to maintain mobility and good foot health out of 62 sample residents. Specifically, the facility failed to schedule diabetic Resident #62 with long toenails to see a podiatrist for nail care. Findings include: I.Facility policy and procedure The facility policy and procedure for foot care was requested from the social service director (SSD) on 3/23/21 at 1:44 p.m., and was not received. II. Resident status Resident #62, age 73, was admitted on [DATE]. According to the March 2021, computerized physician orders (CPO) pertinent diagnoses included, diabetes mellitus, heart failure and generalized muscle weakness with reduced mobility. The 2/25/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing and toileting. She required extensive one person assistance with personal hygiene. She had two unstageable pressure injuries, one which was present on admission. III. Observations and interviews Resident #62's feet were observed with licensed practical nurse (LPN) #6 on 3/22/21 at 4:11 p.m. The resident was lying in bed with light blue boots on. She had a dressing to her right heel. Her toenails were very long, extending approximately 1 cm (centimeter) beyond the end of the toes. LPN #6 said her toenails were very long, and she had wounds to both of her heels (cross-reference F686 pressure injuries). On 3/23/21 at 9:45 a.m., Resident #62's toenails were observed with LPN #1. She said her toenails were very long. She said she told social services and the wound care nurse (WCN) three weeks ago, that Resident #62 needed to be seen by the podiatrist. LPN #1 said the podiatrist needed to see her because she was diabetic, and her toenails needed to be cut. LPN #1 said she could not cut them. She said they were very jagged and she had tried to smooth them with a nail file, but the toenails needed to be cut. The WCN was interviewed on 3/23/21 at 10:26 a.m. She said she notified social services yesterday (3/22/21), that the resident needed to be seen by podiatry for toenail care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD was interviewed on 3/23/21 at 1:44 p.m. She said she was responsible for scheduling podiatry visits at the facility. The SSD said the podiatrist visited quarterly, but would come sooner if there was an urgent need. She said the podiatrist was at the facility in January 2021, but did not see Resident #62. The SSD said she was not on the list. She said the facility had a care conference on 3/16/21, and the assistant director of nursing (ADON) was present. The SSD said the ADON should have brought up the need for podiatry at that time, but he did not. The SSD said the resident had not seen a podiatrist to have her toenails trimmed since she admitted on [DATE]. She said she had not received any messages from the licensed nurse regarding the need for podiatry. The SSD said Resident #62 should have been seen by podiatry due to her long toenails and diabetes. IV. Record review The electronic medical record for Resident #62 was reviewed. There were no notes from the social services department or from a podiatrist documented.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43134 Based on record review, observations and interviews, the facility failed to ensure four (#123, #50, #339 and #13) out of six residents reviewed out of 62 sampled residents were as free from accident hazards as possible and received adequate supervision and assistive devices to prevent accidents. Specifically, the facility to ensure: -Resident #123 received the care and services necessary to prevent a fall. The resident, identified as at risk for falls, had a diagnosis of weakness and reported weakness on 3/11/21. Three days later, she sustained an unwitnessed fall with serious injury (hematoma and bleed). The facility lacked evidence it had recognized and addressed her fall risks, including weakness, in an effort to keep her safe. (Cross-reference F684). -Resident #50, care planned to have an assistive device with staff assistance when ambulating to prevent falls, received such assistance while while ambulating with staff. She fell and sustained a leg fracture. -Resident #339's physician orders, documented on the treatment record, were implemented and communicated to staff. Resident #339 had a history of 11 falls in the facility. -Resident #13's security bracelet was checked for functionality. Findings include: I. Facility policy The fall management policy, dated 9/15/01 and revised on 2/18/20, was provided by the director of nursing (DON) on 3/18/21 at 4:45 p.m. It read in pertinent part: Patients will be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Patients experiencing a fall will receive appropriate care and investigation of the cause. The practice standards section of the policy revealed in pertinent part: Communicate patient's fall risk status to caregivers. Develop an individualized plan of care. Update care plan to reflect new interventions. II. Failure to ensure Residents #123, #339, #13, and #50 were as free from accident hazards as possible and received adequate supervision and assistive devices to prevent accidents. A. Resident #123 1. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #123, age 65, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), the diagnoses included weakness, repeated falls, depression, anxiety, hypotension, muscle weakness, deep vein thrombosis (blood clot), pulmonary embolism (blood clot in the lungs), esophagitis with stenosis (swelling and narrowing of the esophagus). The 2/23/21 minimum data set (MDS) assessment revealed the resident was moderately cognitively intact with a brief interview for mental status score of 11 out of 15. She required two-person physical extensive assistance with mobility, transfers, toilet use and one-person limited assistance with dressing and personal hygiene. She had fallen four days after she was admitted . She was taking an anticoagulant (blood thinning) medication. She did not use supplemental oxygen and required a wheelchair for mobility. A 3/12/21 care plan revealed the resident was at an increased risk for falls because of impaired mobility and a history of falls. The interventions were to provide verbal cues for safety and remind and place call light in reach to use for assistance to transfer or use the toilet. 2. Observations and resident interview On 3/11/21 at 9:30 a.m., Resident #123 laid on her bed with her head up about 45 degrees. Both of her legs were outstretched in front of her. She said she required more assistance with transfers and meals set up to eat than she received. She stated, I need help with a lot of things, like getting into my wheelchair, going to the bathroom. She said she required assistance with transferring to her wheelchair and toileting. She used a wheelchair to move about in her room and in the facility. As she pointed to her bowl of oatmeal with the lid on it beside her on the bedside table, she said, I have been waiting to get help taking this lid off. I am so weak right lately and I need to eat. She said the doctor had told her she was malnourished and needed to eat better. 3. Fall with significant injury 3/14/21 Record review: A nursing progress note dated 3/14/21 at 1:40 p.m. read a certified nurse aide (CNA) alerted registered nurse (RN) #1 that Resident #123 was found on the floor. A 3/15/21 facility to hospital transfer form, dated at 6:00 p.m., revealed the resident was transported to the hospital per a physician order for further evaluation due to an altered mental status with drowsiness, confusion and unclear speech. The transfer form read the resident's vital signs were different from her usual numbers with increased heart rate, lower blood pressure and lower oxygen saturation with oxygen delivery with a nasal cannula. The 3/15/21 hospital records, provided by the DON on 3/22/21 at 4:00 p.m., revealed Resident #123 arrived at the hospital non-responsive except to touch with eye movement and incoherent words. The 3/16/21 computed tomography scan (CT scan) revealed she had a hematoma (pocket of blood inside the body) with a slow bleed. The injury was inoperable because of her frail state and she was transferred to an inpatient hospice unit. The resident passed away on 3/17/21. The facility's fall investigation, received at survey exit on 3/23/21, identified the root cause of the fall was lethargy and oxygen saturation levels were low. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interviews: CNA #5 was interviewed on 3/22/21 at 11:50 p.m. She stated on 3/14/21 when she found the resident on the floor, she believed the resident had been sitting in her wheelchair and fell off and down to the floor on her buttocks. CNA #5 said she and RN #1 used a mechanical lift and assisted the resident into bed. She said the resident was tired the rest of the day. RN #1 was interviewed on 3/23/21 at 3:00 p.m. She said she covered the primary nurse's residents. She said following the resident's fall on 3/14/21, she assisted the resident to bed, performed her assessment and initiated the unwitnessed fall protocol with neurological checks and continued monitoring per the facility standard. She said the resident did not have any injuries at the time of the first assessment. She reported the incident to the primary nurse, licensed practical nurse (LPN) #4, when she returned to duty and she (RN #1) was relieved of monitoring and did not need to monitor the resident after that point. She further said she was not requested to reassess the resident. Resident #123's daughter was interviewed on 3/23/21 at 9:30 a.m. She said Resident #123's spouse was notified of the resident's fall on 3/14/21 and he reported that when he spoke with the resident, she was speaking incoherently. The next day, on 3/15/21, they were notified at 6:00 p.m. that the resident had gone to the hospital and they met her at the emergency room . She said Resident #123 was unresponsive when her family saw her at about 9:30 p.m. The doctors had discussed the treatment for the hematoma with a small bleed that would need surgery. She said the doctors at the hospital told her and her father, the resident now was in a more fragile state because she suffered a large blood loss, and hospice would be most appropriate for her. She said the resident was admitted to a hospice inpatient unit and passed away on 3/17/21 from the injuries of her fall. (Cross-reference F684) 4. Facility failure The facility lacked evidence it had recognized and addressed her fall risks, including weakness, in an effort to keep her safe. See care plan above; contrary to facility policy - to individualize a resident's plan of care and to communicate the resident's fall risk status to caregivers - the level of the resident's fall risk, the factors that created her risk, and directives to staff to minimize them, were not identified. Specifically, there was no reference to the weakness the resident expressed (see above) and no individualized interventions to reduce her risk and to minimize injury given her history (muscle weakness, repeat falls, hypotension), her expressed weakness, and her risk of injury with a fall due to receiving anticoagulant medication. B. Resident #50 1. Resident status Resident #50, age 73, was admitted on [DATE]. According to the March 2021 CPO, the resident's diagnoses included: Alzheimer's disease, history of falling, dizziness, muscle weakness, depression and hypertension. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/2/21 MDS assessment revealed the resident was severely cognitively impaired with a brief interview for mental status score of 2 out of 15. She required extensive one person assistance with bed mobility, transfers, walking in her room, dressing, eating personal hygiene and toilet use. She was frequently incontinent of the bladder and always incontinent of bowel. She had a recent history of falls with injury. The resident's care plan, last revised on 10/25/2020, read she was at risk for falls because of her cognitive loss and mobility and lack of safety awareness. Interventions in place were to provide the resident with extensive assistance as well as an assistive walking device. 2. Observations On 3/18/21 at 12:30 p.m. the resident was walking and holding onto a staff member's arm. She did not have an assistive device for walking. 3. Record review - fall and facility failure The 3/21/21 progress note stated the resident was walking with CNA guidance, and tripped (on something) with her right foot and fell on her left side. She complained of pain and was not able to get off the floor due to pain. A fall investigation, received at survey exit on 3/23/21, read the CNA could not prevent the resident from falling. Neither the progress note nor the facility fall investigation indicated the resident was using an assistive device in addition to staff assistance at the time of fall. 4. Interviews Licensed practical nurse (LPN) #8 was interviewed on 3/23/21 at 12:00 p.m. She stated Resident #50 was walking with a nurse aide and fell . She went to the hospital over the weekend with a lot of pain in her leg. The DON was interviewed on 3/23/21 at 11:15 a.m. She said that Resident #50 was admitted to the hospital after a fall on 3/21/21. She had a fracture to her left upper leg due to the fall and needed surgery to repair the fracture. 43135 C. Resident #339 1. Resident status Resident #339, age 68, was admitted on [DATE]. According to the 2/18/21 computerized physician orders (CPOs), diagnoses included Alzheimer's disease, dementia, a history of falling, anxiety disorder, dysphagia (difficulty swallowing), type 2 diabetes mellitus, muscle weakness, and pelvis stress fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/25/21 MDS assessment revealed the resident had cognitive impairments and had severely impaired decision making skills, based on the staff assessment for mental status. The resident required extensive assistance with transfers, bed mobility, dressing, eating, toilet use and personal hygiene. The resident required total dependence for showering. The resident was frequently incontinent of bladder and always incontinent of bowel. 2. Record review The CPO dated 12/22/19 and revised on 2/18/21 revealed, the resident was to have a fall mat at the bedside when the resident was in bed. The care plan dated 3/17/21 was reviewed and revealed the resident had 11 recorded falls on: 12/5/19, 12/22/19, 3/13/2020, 4/20/2020, 5/20/2020, 7/11/2020, 9/24/2020, 11/7/2020, 11/25/2020, 12/29/2020, and 2/9/21. The treatment administration record (TAR) dated 3/21 was reviewed and revealed the resident was to have a fall mat at the bedside when the resident was in bed every day and night shift when the resident was in bed. The record documented the resident had a fall mat both day and night at the resident's bedside on 3/10 and 3/11/21 and on 3/16/21, although observations (see below) revealed otherwise on these dates. 3. Observations Resident #339 was observed in her bed sleeping on the days and times below. The bed was 22 inches above the floor. The bed was up against the wall on the left side. The right side of her bed was unobstructed and there was no fall mat on the floor next to the bed. -3/10/21 at 11:15 a.m. -3/11/21 at 8:53 a.m. and 3:00 p.m. -3/16/21 at 1145 a.m. -3/17/21 at 8:45 a.m., 9:21 a.m., 10:18 a.m., 10:56 a.m., 11:33 a.m., and 1:14 p.m. -3/18/21 at 12:20 a.m. and 12:20 p.m. 4. Staff interviews CNA #3 was interviewed on 3/18/21 at 12:28 p.m. in Resident #339's room. CNA #3 looked for a fall mat on the side of the resident's bed, under the bed and in the resident's bathroom. She said Resident #339 did not have a fall mat in her room or it would be seen in one of these places. She said she did not recall the resident ever having a fall mat in her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 3/18/21 at 1:58 p.m. in Resident #339's room. LPN #3 said she did not know the resident had a physician's order to have a fall mat by her bed when the resident was in bed. She said she was never instructed that the resident had a fall mat. LPN #3 looked for a fall mat in the resident's bathroom, next to the resident's bed and under the bed. After looking for a fall mat, she said she could not find a fall mat. She said the resident had lived in a different room in the facility and maybe when they changed rooms the fall mat did not move with the resident to the new room. LPN #3 said she would get a fall mat and put it in the resident's room today. 41172 D. Resident #13 Policy and procedure The Patient Security Bracelet policy was received from the director of nursing (DON) on 3/18/21 at 4:45 p.m. The policy documented in pertinent part, Resident/patient security bracelets (e.g. Wanderguard) will be inspected per manufacturers recommendations but at a minimum of every shift for placement and daily for function. 1. Resident status Resident #13, age 59, was admitted on [DATE] and readmitted on [DATE]. According to the March 2021, CPO, pertinent diagnoses included vascular dementia with behavioral disturbance, restlessness, agitation, traumatic brain injury and transient ischemic attacks (TIA) with cerebral infarction (stroke). The 3/1/21 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 8 out of 15. He required supervision of one person with bed mobility, transfers, and toileting. He required limited one-person assistance with dressing and personal hygiene. He ambulated with supervision and a cane or walker. Resident #13 wandered daily and wore an elopement alarm (Wanderguard) bracelet daily. 2. Record review The March 2021 physician's orders were reviewed.The orders dated 9/23/2020 documented OK to place Wanderguard on resident. The March 2021 TAR documented to check the Wanderguard to the left wrist for placement twice daily. However, the TAR did not indicate the Wanderguard was ever checked to ensure it was functioning. It did not indicate when the Wanderguard bracelet was to be changed. The care plan initiated 2/17/2019 documented the resident was at risk for elopement, and had eloped on 1/3/20 and 3/24/20, and attempted to elope on 11/19/20. On 1/4/20 Wanderguard was added to the care plan. There were no instructions for checking the Wanderguard's placement, when to replace it, or checking the function. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An elopement assessment completed 2/27/21 documented Resident #13 was at risk for elopement. The assessment documented he had dementia with a history of actual elopement. It documented his wandering placed him at significant risk of getting into a potentially dangerous place. The assessment documented his wandering intruded on the privacy of others and he was hyperactive with frustration, restlessness or agitation, and had impulsiveness. 3. Interviews LPN #5 was interviewed on 3/18/21 at 11:19 a.m., she said we just visualize the Wanderguard is on. We do not check it for anything else. The assistant director of nursing (ADON) was interviewed on 3/18/21 at 11:22 a.m. He said the Wanderguard is checked for placement. He did not know if it was checked for function. He said he did not know how that would be done. He said he did not know if the Wanderguards expire and are run on a battery. The ADON did not know when the Wanderguard had been changed last. He said he would look into it. The ADON was interviewed again on 3/18/21 at 3:00 p.m. He said the facility had only been checking placement of the Wanderguard, not function. He said he had begun training licensed nurses today on how to check function with a device supplied by the manufacturer. He said once activated, the Wanderguard was good for 90 days. The DON was interviewed on 3/22/21 at 12:28 p.m. She said the facility had begun checking the function of the Wanderguards on 3/18/21 (during survey). The DON said there was the potential for elopement if the device was not checked for function and was not working. 4. Facility follow up On 3/18/21, the March 2021 physician orders were updated to include, check Wanderguard for placement and function every shift for elopement. Wanderguard due to poor safety awareness and expires on 6/18/21. Wanderguard needs to be replaced.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure residents maintained continence or received treatment and services to restore continence to the extent possible for three (#186, #71, and #97) of four residents out of 62 total sample residents. Specifically, the facility failed to: -Ensure Resident #186, #71, and #97 received accurate and thorough bladder and bowel assessments to determine an appropriate treatment plan; and -Implement individualized interventions in response to incontinence for Resident #186, #71, and #97. Findings include: I. Facility policy and procedure The Continence Management policy, dated 6/1/96, and last revised 11/1/19, was provided by the director of nursing (DON) on 3/17/21 at 5:16 p.m. It read in pertinent part, Policy: A urinary incontinence assessment and/or a bowel incontinence assessment and the Three-Day Continence Management Diary will be completed if the patient is incontinent upon admission or readmission, and with a change in condition or a change in continence status. Continence status will be reviewed quarterly and with significant change as part of the nursing assessment. Purpose: To provide appropriate treatment and services for patients with urinary incontinence to minimize urinary tract infections and restore as much normal elimination function as possible. To provide appropriate treatment and services for patients with bowel incontinence and restore as much bowel function as possible. Practice Standards: Identify patient ' s continence status and need for management by reviewing the nursing assessment. If the patient is incontinent, complete the Urinary Incontinence Assessment and/or Bowel Retraining Assessment. Address transient causes for incontinence. Initiate the Three-Day Continence Management Diary if incontinence is not resolved. Develop a plan of care based on the information from the assessments and the diaries. Implement revisions to the plan of care as needed. II. Resident #186 A. Resident status Resident #186, age 84, was admitted on [DATE]. According to the March 2021 clinical physician orders (CPO), diagnoses included neoplasm of uncertain behavior of bladder, weakness, type 2 diabetes mellitus with unspecified complications, and altered mental status. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/3/21 minimum data set (MDS) assessment revealed that the resident had severe cognitive impairment with a brief interview for mental status (BIMS) of 7 out of 15. The resident required two-person extensive assistance for bed mobility, toilet use, and personal hygiene. She required one-person extensive assistance for dressing and eating. According to the MDS, transfers did not occur. She was always incontinent of urine and bowel. A bowel and bladder toileting program had not been conducted. B. Record review Review of Resident #186 ' s electronic medical record (EMR) revealed there were no bowel incontinence or bladder incontinence assessments completed for the resident. Further review of the resident ' s EMR revealed there was no Three-Day Continence Management Diary completed for the resident. Review of Resident #186 ' s comprehensive care plan revealed that she did not have a care plan or interventions for bowel and bladder incontinence. The Nursing Documentation assessment dated [DATE] documented the resident had bowel incontinence and urinary incontinence. C. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 3/18/21 at 11:42 a.m. CNA #5 said Resident #186 did know when she had to go to the bathroom. She said the resident would tell staff when she had to have a bowel movement. She said Resident #186 could not stand, and therefore the resident did not sit on the toilet. CNA #5 said the facility did not have mechanical lift slings with holes in them for toileting residents. She said staff had toileted other residents who required a mechanical lift for transfers. She said staff would transfer the other residents to a shower chair, remove the lift sling, and then reposition the shower chair over a toilet so the resident could use the toilet. She said they had not done that with Resident #186. CNA #5 said staff would transfer Resident #186 to her bed after she was incontinent and provide incontinence care for her. Minimum data set coordinator (MDSC) #1 was interviewed on 3/23/21 at 3:00 p.m. MDSC #1 said she was not able to find a bowel and bladder assessment or a three-day toileting diary in Resident #186 ' s medical record. She said she thought the resident had a foley catheter. III. Resident #71 A. Resident status Resident #71, age younger than 70, was admitted on [DATE], and readmitted on [DATE]. According to the March 2021 CPO, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, acute kidney failure, and constipation. The 1/20/21 MDS assessment revealed that the resident was cognitively intact with a BIMS of 15 out of 15. The resident required two-person extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. He was frequently incontinent of urine and bowel. A bowel and bladder toileting program had not been conducted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident observation and interview On 3/11/21 at 11:33 a.m., Resident #71 was observed in his room. There was a urinal on the floor which the resident said he had dropped. Resident #71 said he was aware of when he needed to use the bathroom, however, he said he was frequently incontinent. C. Record review Review of Resident #71 ' s EMR revealed there were no bowel incontinence or bladder incontinence assessments completed for the resident. Further review of the resident ' s EMR revealed there was no Three-Day Continence Management Diary completed for the resident. Review of Resident #71 ' s comprehensive care plan, initiated on 11/17/16, and revised on 5/10/17, revealed the resident experienced/was at risk for urinary retention. Pertinent interventions included to assist the resident to the toilet at scheduled times, upon rising, before meals, at bedtime, and as needed. Further review of the resident ' s care plan revealed that he did not have a care plan or interventions for bowel and bladder incontinence. D. Staff interviews MDSC #1 and MDSC #2 were interviewed together on 3/23/21 at 9:44 a.m. MDSC #1 said all residents should have a bowel and bladder assessment completed. She said she was unaware if any residents were currently on a toileting program. She said she was not able to find a bowel and bladder assessment or a three-day toileting diary in Resident #71 ' s medical record. MDSC #2 said the toileting diary was part of the bowel and bladder assessment. 43909 IV. Resident #97 A. Resident status Resident #97, over age 90, was originally admitted on [DATE]. According to the March 2021 computerized physician ' s orders (CPOs) diagnoses included cerebrovascular disease, chronic obstructive pulmonary disease (COPD), hemiplegia and hemiparesis following cerebrovascular disease. The 2/2/21 minimum data assessment (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance and one person physical assistance with all activities of daily living. The MDS revealed the resident was frequently incontinent of the bladder and occasionally incontinent of the bowel. She was not on a toileting program to manage incontinence. B. Record review (continued on next page)

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	065415	A. Building B. Wing	03/23/2021

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Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The incontinence section of the comprehensive care plan, last revised 5/11/17, revealed the resident was frequently incontinent of urine and was unable to cognitively or physically participate in a retraining program due to hemiplegia of dominant side, dependence of extensive assist with toileting, and preference of not getting out of bed during the night. The goal was for the resident to have incontinence care needs met by staff to maintain dignity and comfort and to prevent incontinence related complications. Interventions included: -Encourage the resident to consume all fluids during meals. Offer/encourage fluids of choice, initiated 1/21/16; -Monitor for signs and symptoms of infection and report to physician, initiated 1/21/16; -Provide incontinence cares as needed, initiated 1/21/16; and, -Use absorbent products as needed, initiated 1/21/16. There was no bowel incontinence section documented in the care plan. No admission bowel and bladder assessment and no documentation of a three day incontinence diary were found in the medical record. The types of urinary and bowel incontinence were not documented in the medical record. D. Staff interviews The minimum data set coordinators (MDSC #1 and MDSC #2) were interviewed together on 3/23/21 at 9:40 a.m. MDSC #1 said bowel and bladder assessments were completed by nursing staff upon admission to the facility for every resident and upon change of condition or a resident ' s desire to improve incontinence concerns. She said the type of incontinence would be identified and documented in the bowel and bladder assessment. She said she was unsure about three day incontinence studies being conducted for residents with identified bowel and bladder incontinence concerns. MDSC #2 said bowel and bladder training programs would be addressed through restorative therapy and discussed during interdisciplinary team meetings to determine further toileting needs. She said she would have to look for Resident #97 ' s bowel and bladder assessment as she could not find it in the electronic medical records. Non-certified nurse aide #3 (NA #3) was interviewed on 3/22/21 at 12:36 p.m. She said that Resident #97 was fairly independent with bathrooming and only required staff assistance to ensure she safely transferred on and off the toilet. She said the resident was often incontinent of urine before she sat on the toilet and she would sometimes already be urinating as she transferred onto the toilet. She said she did not recall the resident ever being on a toileting program. Licensed practical nurse # 2 (LPN #2) was interviewed on 3/23/21 at 1:48 p.m. She said Resident #97 had been on a diuretic for a long time but began refusing the diuretic in fall of 2020. LPN #2 said the resident was frustrated with how the diuretic caused her more urinary incontinence. She said the medication was discontinued in November 2020 because the resident wanted to have less incontinence episodes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSC #1 and MDSC #2 were interviewed again on 3/23/21 at 3:30 p.m. MDSC #1 said she was unable to find a bowel and bladder assessment for Resident #97 and that the resident was admitted to the facility before medical records were computerized and she could not find paper assessments. MDSC #1 said she did not know if the resident was reassessed for incontinence or if a toileting program was discussed after the resident stopped taking her diuretic in November 2020.

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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** 20287 Based on observations, record review, and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for four (#71, #29, #79, and #62) of five residents reviewed for respiratory care out of 62 total sample residents. Specifically, the facility failed to: -Ensure oxygen tubing was marked with the date the tubing was replaced for Resident #71; -Obtain physician orders for oxygen for Resident #71 and #62; -Administer oxygen as ordered by the physician for Resident #29 and #62; and -Ensure oxygen was included on the comprehensive care plan for Resident #71, #29, #79, and #62. Findings include: I. Facility policy and procedures The Oxygen policy, dated 1/1/04, and revised 11/1/19, was provided by the director of nursing (DON) on 3/22/21 at 4:15 p.m. It read in pertinent part, Verify oxygen order. Set oxygen liter flow per order. Replace disposable oxygen set up every seven days; date disposable oxygen set up and store in treatment bag when not in use. II. Resident #71 A. Resident status Resident #71, age younger than 70, was admitted on [DATE], and readmitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included asthma, atherosclerotic heart disease of native coronary artery without angina pectoris, pneumonitis due to inhalation of food and vomit, and unspecified sequelae of unspecified cerebrovascular disease. The 1/20/21 minimum data set (MDS) assessment revealed that the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. The resident required two-person extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. He required the use of oxygen. B. Observation On 3/11/21 at 10:59 a.m., Resident #71 was observed in his room. He was wearing an oxygen nasal cannula. Resident #71's oxygen concentrator was set on two liters of oxygen per minute. The oxygen tubing was not labeled with the date it was replaced. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review Review of the March 2021 CPO revealed Resident #71 did not have a physician's order for the administration of oxygen. Review of Resident #71's comprehensive care plan revealed the resident did not have a care plan for the use of oxygen. The 1/20/21 MDS assessment documented the resident used oxygen. However, the 3/17/21 MDS assessment documented the resident did not use oxygen. Review of Resident #71's oxygen saturations documented in the electronic medical record (EMR) revealed the resident received oxygen via nasal cannula on the following dates in March 2021: 3/2, 3/3, 3/4, 3/10, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 3/19, 3/20, 3/21, and 3/22/21. D. Staff Interviews Licensed practical nurse (LPN) #7 was interviewed on 3/23/21 at 9:37 a.m. LPN #7 confirmed Resident #71 did not have a physician's order to administer oxygen. She said the resident required oxygen and should have an order for it. Minimum data set coordinator (MDSC) #1 and MDSC #2 were interviewed on 3/23/21 at 4:30 p.m. MDSC #1 confirmed Resident #71 did not have an order for oxygen. She said if the resident did not have an order for oxygen, the nursing staff would be unaware the resident should have oxygen. She also said the 3/17/21 MDS was coded incorrectly and should have been coded that the resident did use oxygen. MDSC #1 said Resident #71's comprehensive care plan should include an oxygen care plan. She said if residents were on oxygen they should have a care plan for the use of oxygen. She said she would update his care plan to include oxygen. 43134 III. Resident #29 A. Resident status Resident #29, age 75, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included syncope and collapse, and nontraumatic chronic subdural hemorrhage. The 12/20/2020 MDS assessment revealed that the resident had moderate cognitive impairment with a BIMS of 12 out of 15. The resident required one-person limited assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. He required the use of oxygen. B. Resident observation and interview On 3/23/21 at 8:49 a.m., Resident #29 was observed in his room. He was not wearing oxygen. There was no oxygen concentrator or portable oxygen tank observed in the resident's room. Resident #29 said he did not use oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review Review of the March 2021 CPO revealed Resident #29 had a physician's order for oxygen at two liters per minute via nasal cannula continuously while sleeping every night shift for hypoxia. The order had a start date of 3/10/21. Review of the resident's comprehensive care plan revealed the resident did not have a care plan for the use of oxygen. The March 2021 treatment administration record (TAR) for Resident #29 documented the resident had received oxygen nightly for the dates of 3/10 through 3/22/21. However, this documentation was not consistent with the resident's EMR documentation of oxygen saturations. Review of Resident #29's oxygen saturations documented in the EMR revealed the resident was on room air and did not receive oxygen on the nights of 3/10 through 3/22/21. D. Staff interview Registered nurse (RN) #2 was interviewed on 3/23/21 at 9:09 am. RN #2 said Resident #29 did not wear oxygen. She confirmed the resident had a physician's order for oxygen, but did not have any oxygen equipment in his room. She said if a resident had an order for oxygen there should be oxygen equipment in the resident's room so oxygen could be administered per the physician'ss order. She said the order should be discontinued because the resident did not wear oxygen. IV. Resident #79 A. Resident status Resident #79, age 83, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, shortness of breath, acute on chronic diastolic (congestive) heart failure, and dependence on supplemental oxygen. The 2/2/21 MDS assessment revealed that the resident had moderate cognitive impairment with a BIMS of 11 out of 15. The resident required one-person limited assistance with bed mobility, transfers, dressing, and toilet use. She required one-person extensive assistance with personal hygiene. She required the use of oxygen. B. Resident observation and interview On 3/23/21 at 8:53 am., Resident #79 was observed in her room. She was wearing an oxygen nasal cannula. Resident #79's oxygen concentrator was set on four liters of oxygen per minute. The resident said she was on oxygen all the time. C. 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	Review of the March 2021 CPO revealed Resident #79 had a physician's order for oxygen at four liters per minute via nasal cannula continuously every shift for COPD. The order had a start date of 1/28/21, and was revised on 3/19/21. Review of the resident's comprehensive care plan revealed the resident did not have a care plan for the use of oxygen. The March 2021 treatment administration record (TAR) for Resident #79 documented the resident had received oxygen continuously every shift from 3/1 through 3/22/21. However, this documentation was not consistent with the resident's EMR documentation of oxygen saturations. Review of Resident #79's oxygen saturations documented in the EMR revealed the resident was on room air and did not receive oxygen for the following dates and times: -3/1/21 at 9:50 p.m.; -3/2/21 at 5:13 a.m., 1:13 p.m., and 9:45 p.m.; -3/3/21 at 5:14 a.m.; -3/4/21 at 3:08 a.m., 2:34 p.m., and 10:32 p.m.; -3/5/21 at 3:12 a.m. and 10:10 p.m.; -3/6/21 at 9:36 p.m.; -3/7/21 at 5:19 a.m. and 2:28 p.m.; -3/8/21 at 5:16 a.m., 3:01 p.m., and 9:54 p.m.; -3/9/21 at 2:06 a.m., 3:44 a.m., and 11:25 p.m.; -3/10/21 at 5:05 a.m. and 9:40 p.m.; -3/11/21 at 5:43 a.m., 2:46 p.m., and 9:36 p.m.; -3/12/21 at 5:16 a.m.; -3/13/21 at 5:12 a.m. and 10:26 p.m.; -3/14/21 at 7:21 p.m.; -3/15/21 at 9:38 p.m.; -3/16/21 at 5:48 a.m. and 11:18 p.m.; -3/17/21 at 6:26 a.m.; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/19/21 at 9:36 p.m.; -3/20/21 at 5:46 a.m.; and -3/22/21 at 3:03 p.m. 41172 V. Resident #62 A. Resident status Resident #62, age 73, was admitted on [DATE]. According to the March 2021, computerized physician orders (CPO) pertinent diagnoses included, diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart failure and generalized muscle weakness with reduced mobility. The 2/25/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing and toileting. She required extensive one person assistance with personal hygiene. She was on oxygen and complained of shortness of breath when lying flat. B. Observations On 3/10/21 at 4:30 p.m., Resident #62 was in her room, in her wheelchair. She had oxygen on via nasal cannula. The oxygen concentrator was set on four liters. On 3/16/21 at 11:06 a.m., Resident #62 was in her room, in her wheelchair. She had oxygen on via nasal cannula. The oxygen concentrator was set on four liters. On 3/18/21 at 11:55 a.m., Resident #62 was in her room, in her wheelchair. She had oxygen on via nasal cannula. The oxygen concentrator was set on four liters. C. Record review The physician's orders for March 2021 were reviewed. There was no order for oxygen. The care plan was reviewed. There was no care plan related to oxygen use. D. Interviews Certified nurse aide (CNA) #3 was interviewed on 3/18/21 at 4:56 p.m. She said Resident #62 used oxygen. She said she used two or three liters, I don't know. She went into the resident's room and looked at the oxygen concentrator. She said, it is on three and half liters, so I guess that's what she uses. She said the CNA kardex does not tell her how many liters of oxygen the resident should be on. She said she would have to ask the nurse how many liters to put a resident on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #4 was interviewed on 3/18/21 at 4:58 p.m. She said she did not know how many liters of oxygen Resident #62 was on. She reviewed the resident's kardex. CNA #4 said it was not on the kardex, and she would have to ask the nurse how many liters the resident was on. Licensed practical nurse (LPN) #5 was interviewed on 3/18/21 at 5:00 p.m. She said she was an agency nurse and had only been at the facility two days. She said she did not know Resident #62, or if she was on oxygen. She checked the residents physician orders and said there was no order for oxygen. LPN #5 said if she used oxygen, there should have been an order. The assistant director of nursing (ADON) was interviewed on 3/18/21 at 5:00 p.m. He reviewed the resident's orders. He said Resident #62 was on oxygen and should have had an order. He said he was unable to locate a current or discontinued order for oxygen. He reviewed her care plan. The ADON said Resident #62 did not have a care plan related to oxygen use, and she should have one. The ADON said he did not know how many liters of oxygen per minute the resident should have been on. He said it should have been on the CNA kardex, but since it was not on the care plan it did not appear on the CNA kardex. The director of nursing (DON) was interviewed on 3/22/21 at 12:38 p.m. She said the use of oxygen requires a physician order. She said the oxygen does not appear on the CNA kardex, and the CNA would have to ask the nurse how many liters of oxygen the resident was on. The power of attorney (POA) for Resident #62 was interviewed on 3/23/21 at 1:14 p.m. She said the resident had been on oxygen at home prior to admission to the facility. Facility follow up On 3/18/21, a physician's order documented, oxygen at two liters via nasal cannula continuously every shift for COPD. On 3/22/21 at 4:11 p.m., the resident was observed in her room on oxygen via nasal cannula. The oxygen concentrator was set on three liters, despite the physicians orders for two liters per minute. LPN #6 was present. She said she did not know how many liters per minute of oxygen Resident #62 was supposed to be on.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43909 Based on observation, interviews and record review, the facility failed to ensure an adequate pain management program was in place for one resident (#386) of 62 sample residents. Specifically, the facility failed to ensure: -Resident #386 had pain scale parameters in place to determine proper pain medication dosages; -Resident #386 received a thorough pain evaluation upon admission to the facility; and -Resident #386's pain management program was adjusted and new interventions were attempted when her pain levels continued to increase. These facility failures contributed to the resident experiencing chronic unmanaged pain that was not effectively treated with the pain management program provided by the facility. Findings include: I. Facility policy and procedure The facility pain management policy, last revised 11/1/19, was provided by the director of nursing (DON) on 3/18/21 at 4:45 p.m. It read in pertinent part: Patients will be evaluated as part of the nursing assessment process for the presence of pain upon admission/readmission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals and preferences is provided to patients who require such services. An individualized, interdisciplinary care plan will be developed and include: -Addressing/treating underlying causes of pain to the extent possible; -Non-pharmacological and pharmacological approaches; -Using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms. Patients receiving interventions for pain will be monitored for the effectiveness and side effects (e.g., constipation, sedation) in providing pain relief. Document: -Non-pharmacological interventions and effectiveness; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Effectiveness of PRN [pro re nata, as the need arises] medications. -Ineffectiveness of routine or PRN medications including interventions, follow-up, and physician/APP [advanced practice provider] notification; -Side effects, if present, and notification of physician/APP. II. Resident #386 A. Resident status Resident #386, under the age of 50, was admitted to the facility on [DATE]. She was admitted with hospice care. According to the March 2021 computerized physician's orders (CPOs), diagnoses included malignant neoplasm of cervix uteri (cervical cancer), hydronephrosis (excess fluid in the kidneys), and cellulitis of the right and left lower limbs. The 2/17/21 minimum data assessment (MDS) assessment had not completed the brief interview for mental status (BIMS) at the time of survey. Based on resident interviews, observations (3/10 - 3/23/21) and diagnoses, Resident #386 had no cognitive deficits. She required supervision and setup help only for bed mobility, transfers, walking in her room, eating, and dressing. She required supervision and one person assistance with toileting and personal hygiene. B. Resident observations and interviews On 3/11/21 at 9:34 a.m., Resident #386 was in her room sitting on her bed. She said she was in too much pain to talk. She was grimacing and said that her pain is from the wounds on her back which per interview were from placement of a nephrostomy tube and coccyx wound. On 03/16/21 at 11:24 a.m. Resident #386 was in her room sitting on her bed. She said she was in a lot of pain and rated her pain as an 8 out of 10 (with 10 being the worst pain). She said the nurse had given her pain medication earlier but she was still in a great deal of pain. On 03/18/21 at 11:45 a.m. Resident #386 was in her room sitting on her bed. She said her pain level was 7 out of 10. She said she received one pain medication in the morning and would get more later for the pain from her lower back wound. C. Record Review 1. Pain assessment The 2/11/21 nursing documentation admission assessment revealed Resident #386 had pain located in the sacral area, her reported level of pain was 3 out of 10 upon admission, and she was on prescribed medications for pain management and hospice for comfort care. No additional pain evaluation or documentation was discovered or provided during the survey (3/10 - 3/23/21). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The nursing home administrator (NHA) provided additional documentation via email on 3/24/21 at 4:20 p.m. The additional documentation contained a hospice initial visit assessment from 1/21/21. The hospice initial visit assessment revealed the resident had a goal of keeping her pain level at 5 out of 10. It also revealed the resident had constant pelvic pain and bilateral lower leg pain. It revealed the resident felt that narcotic medications made her incontinent, which she did not like. It revealed that physical exertion and positioning worsened both pelvic and lower extremity pain, and that rest, position changes, prescription medications, and stretching helped relieve pain. It also revealed that on the numeric pain scale, 7-10 was indicative of severe pain. The information found in the 1/21/21 hospice assessment was not reflected in the resident's care plan or any of the facility documentation reviewed during the survey (3/10 - 3/23/21) Additionally, the 1/21/21 hospice assessment was completed prior to the resident's admission to the facility on [DATE] and did not reflect the resident's reported pain from her nephrostomy tube and coccyx wound. 2. Care plan The pain section of the comprehensive care plan, last updated 2/12/21, identified Resident #386 was at risk for alterations in comfort related to chronic pain. The goal was for the resident to achieve acceptable levels of pain control through the review period. Interventions listed in the care plan were: utilize pain scale, monitor for non-verbal signs/symptoms of pain and medicate as ordered, and assist the resident to a position of comfort, utilizing pillows and appropriate positioning devices. No resident pain goals, acceptable levels of pain or pain threshold numbers, or non-pharmacological interventions were documented in the care plan. No new pain management interventions were added after 2/12/21. 3. CPOs The March 2021 CPOs revealed orders for pain monitoring every day shift and every night shift. The orders read as follows: Pain Monitor (able to communicate) Are you free of pain or hurting? If no, indicate response through chart code: PI (if new or change in pain, complete pain eval). The March 2021 CPOs revealed the following pain medications, all with order and state date of 2/11/21 for Resident #386: -Hydrocodone-Acetaminophen tablet 5-321 milligrams (MG): Give one tablet by mouth every four hours as needed for mild/moderate pain; -Hydrocodone-Acetaminophen tablet 5-325 MG: Give two tablets by mouth every four hours as needed for severe pain; -Ibuprofen tablet 200 MG: Give 200 mg by mouth every eight hours as needed for pain; -Morphine Sulfate (Concentrate) Solution 20 MG/milliliter (ML): Give 0.25 ml by mouth every one hours as needed for pain; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Morphine Sulfate ER Tablet Extended Release 15 MG: Give 30 MG by mouth two times a day for pain. The orders did not identify the parameters between mild/moderate pain levels and severe pain levels. 4. Medication administration record (MAR) The March 2021 MAR revealed Resident #385 was monitored for pain once during day shift and once during night shift as per the physician orders above. On 3/16/21 and 3/22/21, the MAR documented PI, the chart code for when the resident had no pain. However, see observations above on 3/16/21 (resident reported pain at level 8) and documented reported pain levels for the two dates were 9 and 10 respectively. The March 2021 MAR revealed Resident #385 received one hydrocodone-acetaminophen tablet 5-325 mg prn for mild/moderate pain on the following dates due to the following reported pain levels: -3/11/21: Pain level of 8; -3/11/21: Pan level of 5; -3/12/21: Pain level of 4; -3/12/21: Pain level of 6; -3/13/21: Pain level of 8; -3/17/21: Pain level of 8; -3/20/21: Pain level of 6; -3/21/21: Pain level of 6; -3/22/21: Pain level of 10; -3/22/21: Pain level of 7; -3/23/21: Pain level of 8; -3/23/21: Pain level of 7 The March 2021 MAR revealed Resident #385 received two hydrocodone-acetaminophen tablet 5-325 mg prn for severe pain on the following dates due to the following reported pain levels: -3/14/21: Pain level of 7; -3/15/21: Pain level of 9; -3/15/21: Pain level of 8; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-3/16/21: Pain level of 9; -3/19/21: Pain level of 5; -3/20/21: Pain level of 7 The CPOs and the MAR did not identify the parameters between mild/moderate pain and severe pain. The resident received different prn medication dose levels for various levels of pain, contributing to inadequate pain medication when severe pain was reported (per the hospice evaluation of her pain on 1/21/21). Further, there was no documentation on the MAR that the resident had refused two tablets when she reported severe pain. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 3/11/21 at 9:41 a.m. She said Resident #386 had chronic pain and much of her pain was related to the wounds she had on her lower back. LPN #2 said that the resident typically did not want to take extra pain medications because they made her constipated. LPN #2 was interviewed again on 3/22/21 at 12:26 p.m. LPN #2 said Resident #386 received scheduled morphine extended release 30mg three times per day and had several prn medication options for breakthrough pain. She said she would check on the resident in the morning and offer her prn medications of morphine or hydrocodone. -She said the resident preferred hydrocodone and felt that the morphine did not help her pain, although the physician increased her scheduled morphine dosage on 3/18/21. LPN #2 said the resident seemed to be in pain all the time and thought her pain regimen may need to be addressed again. However, she did not indicate the resident's report that morphine was ineffective had been reported to the physician. -She said the resident was fairly independent and could reposition herself independently, so medications were the only thing used to address her pain. She said she could not think of any non-pharmaceutical interventions used for the resident's pain. -She said she was unable to find a pain assessment in the resident's medical records and said a pain assessment should have been completed upon admission.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43134 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 in inadequate staffing, the facility failed to perform activities of daily living (ADL) cares for residents including assistance for residents for meal assistance, deliver meal trays timely to maintain the foods integrity, implement measures to prevent pressure ulcers Cross-reference F-677, Maintain activities of daily living for dependent residents; Cross-reference F-686, Treatment, prevent pressure ulcers; Cross-reference F-804, Palatable food; Cross-reference F-684, quality of care; Cross-reference F-689, Accident hazard; and; Cross-reference F-695, Respiratory therapy. Findings include: I. Resident census and conditions According to the 3/10/21 Resident Census and Conditions of Residents report, the resident census was 142. The following care needs were as identified: -99 residents needed assistance of one or two staff with bathing and 38 residents were dependent. One resident was independent. -71 residents needed assistance of one or two staff members for toilet use and 48 residents were dependent. 23 were independent. -66 residents needed assistance of one or two staff members for dressing and 51 were dependent. Two residents were independent. -94 residents needed assistance of one or two staff members and 29 were dependent for transfers. Eight residents were independent. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-74 residents needed assistance of one or two staff members with eating and nine were dependent. 50 residents were independent. II. Staffing requirements for each station According to the desired staffing pattern provided by and interview with the director of nursing on 3/23/21 at 3:31 p.m. A. 100 ' s, 200 ' s, 300 ' s, and 400's Day shift: Three to four licensed nurses and six certified nurse aides (CNA) Evening shift: Three to four licensed nurses and six CNAs Night shift: Two licensed nurses, with a third nurse position that ends at 9:00 p.m. and three CNAs B. 600's Day shift: Two CNAs and one licensed nurse. Evening shift: Two CNAs and one licensed nurse. Night shift: One CNA and one licensed nurse. C. 700's hall, memory care unit 37 residents Day shift: two licensed nurses working 12 hour shifts and three CNAs Evening shift: three CNAs Night shift: one licensed nurse working 7:00 p.m. to 7:00 a.m. and two CNAs D. 800's hall, observation unit Day shift: One to two CNA and one licensed nurse Evening shift: One to two CNA and one licensed nurse. Night shift: One CNA and one licensed nurse. III. Open positions Excluding the 900's hall, due to the temporary closure, there were eight licensed nurses and nine CNA positions open. As well as an RN supervisor position was open. IV. Observations On 3/10/21 at 12:05 p.m. a CNA was passing lunch trays. She said Everybody's serving today. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/10/21 5:25 p.m. a man who was visiting with his mom, walked into the hall from a room in the 400's hall. He said, Can someone help, my mom's roommate fell on the floor, I can ' t find anyone. On 3/17/21 at 12:42 p.m., the Resident #186's meal continued to sit in the holding hot box. The hot box was not plugged into the wall. At 12:50 p.m., she continued to wait for her meal. The CNA #7 was interviewed at 12:50 p.m. The CNA said that Resident #186 had not been assisted to eat yet, because she had to finish assisting another resident, and therefore she had to wait as there was no other staff available to assist the resident with eating. At 1:04 p.m., Resident #186 was served her meal and received the one on one assistance to eat. V. Resident interviews Resident #39 was interviewed on 3/10/21 at 5:38 p.m. She said she had to wait for assistance to get out of bed and assisted to her chair. She said it was not timely. Resident #123 was interviewed on 3/11/21 at 9:30 a.m. She said the staff always seem rushed. When they delivered her breakfast tray, they did not stay to help. She depended on staff to assist her with meals to take the covers off the bowls and cups. Resident # 84 was interviewed on 3/11/21 at 10:31 a.m. She stated that the staff mostly had a limited amount of people and did not seem to have time to help. She had broken her hip and needed a lot from them to move her, transfer and help with incontinent care the most. Resident #386 was interviewed on 3/11/21 1:25 p.m. The resident said when she needed water or something, sometimes it takes about 20 minutes to answer the call light. VI. Interviews Certified nursing aide (CNA) #10 was interviewed on 3/18/21 at 12:41 a.m. She said there was two CNAs for the four hallways (100's s, 200's, 300's, and 400's), with nine residents who needed a mechanical lift that required two people to use. For the 300's and 400's hallways she cared for, had 21 residents who needed to be changed every 2 hours. It was difficult to take care of all the resident's well when she also had to answer call lights. Nursing aide (NA) #4 was interviewed on 3/23/21 at 9:34 a.m. said she was the only aide for 18 residents that morning. CNA # 11 was interviewed on 3/18/21 at 12:20 a.m. She stated that she was the one CNA for the 100's and 200's hallways and one for the 300's and 400's. The resident's who needed two people to care for them, had the two CNAs and did not have time to complete all the needed tasks. The DON was interviewed on 3/23/21 at 3:40 p.m. She stated that there were two CNAs for the four hallways, with over 60 residents, she provided another nurse so the two CNAs were sufficient. The DON said if a CNA needed help on a specific unit, then the CNA was instructed to alert the nurse who would then ask an administration nurse to assist.

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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. 43135 Based on resident interviews, staff interviews, and the tasting of test trays, the facility failed to consistently serve food that was palatable, attractive, and at the proper temperature. Findings include: I. Resident interviews Resident #97 was interviewed on 3/10/21 5:11 p.m. The resident said the food did not taste good or look good. She said they put everything on one plate and then it is served cold and you just look at it and it does not look like something you want to eat. Resident #116 was interviewed on 3/11/21 at 10:00 a.m. The resident said the food was not always served hot. Resident #386 was interviewed on 3/11/21 1:27 p.m. The resident said the food was not my favorite food. She said there was not any Asian food, and she had to ask for friends to bring in food. She said the soup was served at room temperature. Resident #287 was interviewed on 3/11/21 at 2:13 p.m. The resident said the food did not look appetizing. Resident #81 was interviewed on 3/11/21 at 2:21 p.m. The resident said he did not like the food. Resident #49 was interviewed on 3/23/21 at 2:00 p.m. She said she received her meals served in her room. She said the food was often cold in the morning. She said it was up to the certified nurse aides (CNA ' s) to deliver the food trays and not the dietary department staff. She said the CNA's were very busy in the mornings doing many things for the residents and she said that was why the food was often served late and cold. She said she noticed the hot boxes were not always plugged in when they were in the hallways filled with food and that was why the food was cold also. She said she felt if the staff would plug in the hot boxes our meals would be warm. II. Test tray A test tray, regular diet was evaluated immediately on 3/17/21 at 6:26 p.m. when the full tiered cart was completed and sent to the 700 hallway for the residents. -The first plate prepared at 5:38 p.m. was used for the evaluation at 6:26 p.m. -The plate was covered with plastic wrap and contained shepherd's pie, soup, and was served with a side cup of ice cream. -The shepherd's pie temperature was 109 degrees F, which was a drop of 56 degrees F from the original temperature of 165 degrees. The shepherds pie was cool to the palate. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The soup's temperature was 112 degrees F, which was a drop in temperature of 40 degrees from the original temperature of 152 degrees F. The soup was cool to the palate. -The ice cream cup was half way melted and turned to liquid. Interview The dietary manager (DM) was interviewed again on 3/18/21 at 12:12 p.m. He said today the kitchen sent out two tiered carts of trays of food instead of just one cart to the memory care unit. He said by using two carts instead of one, the plate domes could cover each plate and fit into the cart that took the food from the kitchen to the unit. He said by using two carts and food plate domes, the food would remain warmer for longer amounts of time. He said that he and the district manager met and agreed that the food would be kept warmer if two carts were used with domes and not just one cart with plastic wrap over each plate. He said he tested the food today and the food had stayed warm with domes being put on the top of the plates. The dietary manager (DM) was interviewed on 3/23/21 at 2:21 p.m. The DM said the heated carts should always be plugged in. He said then it maintained the temperature. III. Alternatives A. Observations On 3/11/21 at 10:25 a.m. a certified nurse aide (CNA) pushed a three tiered cart with snacks and a container of water down the 700 hallway by the nurse's station. Resident #12 said she was hungry and asked for a snack. The CNA said she only had soda crackers because all of the good stuff was taken already. She gave the resident a two pack of soda crackers and a cup of water. She did not offer the resident any other alternatives to eat. The resident asked if there were any other snacks she could have to eat besides soda crackers and water. The CNA said no, the crackers were all that was left to give because the other residents ate the other snacks. On 3/18/21 at 12:25 p.m. Resident #134 was in the resident assisted dining room in the memory care unit. She was seated in her wheelchair at a dining room table with a meal of lasagna in front of her. She did not eat it and repeatedly stated out loud that she did not like this type of food. She said she never liked this type of food. Four staff members assisted other residents nearby and no one offered her an alternative meal. -At 12:33 p.m. another staff member entered the dining room. Resident #134 said to the staff member that she did not like this type of food. The staff member said to Resident #134 just try and eat what you can, maybe just eat the ice cream on your table. The resident said but I do not like this kind of food. The staff member did not respond further to the resident. -At 12:46 p.m. another staff person entered the dining room and asked the resident if she would like more lasagna. The resident loudly said she did not like this type of food. The staff person did not respond to the resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:48 p.m. Resident #134 was escorted in her wheelchair out of the dining room by licensed practical nurse (LPN) #3. The resident did not eat any of the food on her plate. The resident said to LPN #3, I did not like my food, can I please have an apple? LPN #3 said they did not have apples but she would get her a peanut butter and jelly sandwich. Resident #134 was escorted to the memory care unit's activity room. -At 12:55 p.m. Resident #134 was at an activity room table and did not have an alternative food given to her. B. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 3/18/21 at 4:50 p.m. She said the residents of the memory care unit of the facility were never offered alternatives to eat for meals. She said they get what they get from the kitchen and nothing else. She said Resident #134 did not like the lunch that was served and requested an apple but they did not have apples so she was offered a peanut butter and jelly sandwich. She said a peanut butter and jelly sandwich was not as nutritious as the meal but they do not give us alternative meals. She said if we want an alternative meal for a resident we must go to the kitchen ourselves to get an alternative meal. She said it was too much work to walk to the kitchen and get something else. She said it would be helpful if the kitchen gave us a loaf of bread and lunch meat to keep in our unit refrigerator but they do not. She said what they gave us was all we had. She said she had to go to the kitchen to get bread, peanut butter, and jelly for the resident because they do not keep those supplies on the unit. LPN #9 was interviewed on 3/18/21 at 12:15 p.m. She said whatever food was in our refrigerators on the memory care unit was what the staff had to give the residents for snacks at night. She said the dietary department brought snacks for the refrigerators. She said the nursing staff did not have a key to the main kitchen in the facility. She said the doors to the kitchen were locked at night and the staff could not go in and get food. The dietary manager (DM) was interviewed on 3/23/21 at 2:20 p.m. The DM said the kitchen could easily send a few alternative plates with the meals for the memory care residents. The DM said he understood that if 21 people on the memory care unit were all sent shepherd's pie for a meal someone may not want that meal and prefer something else. The DM said snacks were always available to the facility and provided by the kitchen. He said the nursing staff can always walk in the kitchen anytime for food. He said dry foods or the refrigerator foods are available to staff for the residents at any time. He said the dietary staff leave at night between 8:30 p.m. - 9:00 p.m. and the kitchen doors are not locked. He said the nursing staff can get into the kitchen at night also because the doors to the kitchen are never locked. He said the staff can call on the phone during the day too and the dietary department would send any requested items of foods. He said he had many snack options in the kitchen which included apples or bananas, cookies, different types of crackers and sodas. He said he had not done an all staff in-service to train staff about alternatives and snacks in about six months. He said he would do training for all of the staff in the facility sometime in the near future.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43135 Based on observations and interviews the facility failed to serve food to the residents with proper kitchen sanitation with food service. Specifically the facility failed to ensure: -Ready to eat foods were not touched with contaminated gloves; -Staff heating foods for residents were knowledgeable in reheating temperatures; and -Temperatures were monitored for refrigerators storing resident food. Findings include: I. Touching ready to eat food items The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view It reads in pertinent part; If used, single-use gloves shall be used for only one task, such as working with ready-to-eat food. Single-use gloves shall be used for no other purpose, and discarded when damaged, when interruptions occur in the operation, or when the task is completed. Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and before handling or putting on single-use gloves for working with food, and between removing soiled gloves and putting on clean gloves. A. Observations On 3/17/21 at 10:39 a.m., the activity assistant #3 was observed to touch the cookies with gloved hands. He would get a cookie from the package, then give the cookie to a resident, he would then touch the door knobs, knock on doors and push the cart with the same gloves and then proceed to pick up another cookie and serve it to a resident. No handwashing or glove changing occurred. The evening tray line was observed on 3/17/21 beginning at 5:15 p.m. The dietary cook (DC) used his gloved hands to take two premade dinner rolls from a bag and four slices of bread from another bag. The DC then placed the rolls and bread on four different dinner plates. The DC was observed to touch other items, such as the tray cards, the steamer with the same gloved hands. The dietary manager (DM) told the DC at 5:31 p. m. to always use the metal tongs when getting the bread and to never use his hands whether he was wearing gloves or not. - At 5:39 p.m. the DC used his gloved hands to reach in the dinner roll bag and took two rolls and put them on dinner plates that were to be served to the residents in memory care. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 5:55 p.m. the DC used his gloved hands to reach in the dinner roll bag and took two more rolls and put them on dinner plates that were to be served to the residents in memory care. -At 5:58 p.m. the DC used his gloved hands to reach inside a potato chip bag and a hotdog bun bag. He used his gloved hands to place a handful of chips and one hotdog bun on a plate. -At 6:17 the DC used his gloved hands to take a dinner roll out of a bag and put on a plate which had tuna fish on it. B. Interviews The dietary manager (DM) was interviewed on 3/23/21 at 2:24 p.m. He said gloved hands were never to be used to touch the food that was put on a serving plate. He said tongs should always be used to when touching ready to eat foods. He said that he would ensure the activity staff received training on how to handle ready to eat foods. II. Reheat items A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYIiuu2v1G/view It reads in pertinent part; Food safety food that is cooked and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds. B. Observations On 3/23/21 at 11:00 a.m., the activity assistant (AA) #2 was observed to go from room to room asking residents if they would like to have a bowl of shrimp and noodles. The cart the AA #2 was pushing had the plastic bowls of the shrimp and noodles. The AA #2 entered the satellite kitchen and placed a shrimp bowl into the microwave. The AA #2 said she was going to reheat the shrimp and noodle bowl to 140 degrees F. She said the instructions said to heat for two minutes. Interviews The AA#2 was interviewed on 3/23/21 at 11:00 a.m. She said that the residents had requested to have shrimp and noodle bowls. She said it was an activity. AA #2 said she would take orders and then heat the noodles up and then serve. AA #2 also said they kept the [NAME] soup bowls in the admission office refrigerator and would store items there as needed. The dietary manager (DM) was interviewed on 3/23/21 at approximately 11:15 a.m. The DM was informed of the temperature the AA #2 was going to heat the [NAME] soup to. He said the soup needed to be heated to 165 degrees F. He said he would provide training to the activity personal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	20287 III. Refrigerators A. Observations On 3/23/21 at 11:05 a.m., the refrigerator in the admissions office, had no thermometer in the refrigerator or the freezer. The freezer contained ice cream, chocolate syrup which was used for residents. There were no logs for showing the temperature was monitored for the refrigerator/freezer unit. B. Interviews The nursing home administrator (NHA) was interviewed on 3/18/21 at 11:12 a.m. She said the only thing in the admission office refrigerator should have was water for staff and visitors. She said there should never be resident food in the admission office refrigerator. She said she was unaware there was not a thermometer or a log to record temperatures in the admission ' s office refrigerator. The admissions/marketing director (AMD) was interviewed on 3/18/21 at 11:20 a.m. She said the refrigerator in her office contained staff lunches, waters, chocolate syrup for the residents, sometimes ice cream for the residents and that morning had the soup bowls stored in it. She said she did not have a thermometer. She said the dietary staff did not check the refrigerator in her office. The DM was interviewed on 3/18/21 at 11:21 a.m. The DM said his staff kept thermometers and logs of temperatures for the dietary refrigerators. He said his did not maintain the refrigerator in the admissions office. He also observed the refrigerator/freezer had no thermometers.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 20287 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to, quality of life, and quality of care. Findings include: I. Cross-reference citations Cross-reference F689: The facility failed to ensure resident safety with accident hazards. The facility's failure to identify falls and address the falls with major injuries resulted in the facility being cited at a harm G level. Cross-reference F684: The facility failed to receive treatment which was in accordance with professional standards of practice. The facility's failure to identify and provide treatment in accordance with professional standards was cited at a harm G level. Cross-reference F686: The facility failed to prevent the development of unstageable pressure injury. The facility's failure to identify and prevent the pressure ulcer was cited at a harm G level. Cross-reference F697: The facility failed to manage a resident's pain. The facility's failure to treat the resident's pain was cited at a harm G level, Cross-reference F677: The facility failed to ensure dependent residents received assistance with activities of daily living (ADL). Cross-reference F679: The facility failed to ensure an ongoing resident centered activities program to meet the needs and interests of residents. Cross-reference F695:The facility failed to ensure respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan. II. Facility policy and procedure The policy and procedure for the QAPI program, last updated on 1/21/21, was received on 3/24/21 via email. The policy read in pertinent parts, (name of facility) is committed to incorporating the principles of Quality assurance and performance Improvement (QAPI) into all aspects of the center work processes, service lines, and departments. All staff and stakeholders are involved in QAPI to improve the quality of life and quality of care that our patients and residents experience. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The QAPI program is ongoing, integrated, data driven and comprehensive addressing all aspects of care, quality of life and resident -centered rights and choice. The QAPI processes and improvements are based on evidence, drawing data from multiple sources, prioritizing improvement opportunities, and benchmarking results against developed targets . III. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies. F689 accident/hazards During the 4/24/19 recertification survey, F 689 was cited at a G harm level. During an abbreviated survey on 7/11/19 F 689 was cited at a D level potential for more than minimal harm. During an abbreviated survey on 9/27/19 F 689 was cited at a D level potential for more than minimal harm. During an abbreviated survey on 1/5/21 was cited at a D level. During the recertification survey on 3/23/21 F 689 was cited at a G harm level. F 677 activities of daily living During the 4/24/19 recertification survey, F 677 was cited at a D level potential for more than minimal harm. During an abbreviated survey on 9/27/19 F 677 was cited at a D level potential for more than minimal harm During an abbreviated survey on 1/5/21 was cited at a D level. During the recertification survey on 3/23/21 F 677 was cited at a E level for more than minimal harm at a pattern level. F 812 kitchen sanitation During the 4/24/19 recertification survey, F 812 was cited at a F level potential for more than minimal harm at widespread level. During the 3/23/21 recertification survey, F 812 was cited at a F level potential for more than minimal harm at widespread level. IV. Interviews The nursing home administrator (NHA) was interviewed on 3/23/21 at 5:18 p.m The NHA said the QAPI committee met monthly to trend out issues. She said the interdisciplinary team (IDT) attended, including the medical director and the pharmacist. The NHA said the meeting had an agenda. She said the agenda included looking at different policies, weight loss, falls, antibiotics and review with human resources the staff turnover rate. The NHA said the QAPI committee used information gathered from resident council minutes, family satisfaction surveys, corporate reports and any data from trends. The NHA said that the QAPI committee had not identified any concerns with activities of daily living, such as nail care and meal assistance. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the QAPI committee had not identified concerns with oxygen and physician orders not being followed. She said the expectation was for the physician's orders to be followed. The NHA said the committee reviewed pressure ulcers acquired in the facility. She said the physician had identified the staff needed more training with understanding of how to stage the pressure ulcers. She said they would also review the cause and the effect of the pressure injury. The NHA said the QAPI committee had not identified pain. She said the outside pain clinics could not be used during COVID-19. She said that pain management for residents was spoken about in the psychotropic drug meetings, however, had not identified pain assessments were not completed. The NHA said falls were discussed in the QAPI meetings. She said falls were looked at on how to protect the resident from falls. She said that when the residents were recovering from COVID-19 they were weak. She said the QAPI committee reviews the interventions to prevent falls and put new interventions in place. She said the QAPI committee reviews the interventions to prevent falls and put new interventions in place. She said they had fairly new staff and have identified they need more training and management staff needed to help more.