STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on interviews and record review, the facility failed to ensure consent was obtained for the use of psychotropic medications for two (#31 and #47) of five residents reviewed for unnecessary medication of out 34 sample residents. Specifically, the facility failed to ensure consents that reviewed the risk associated were obtained for the usage of psychotropic medications for Residents #31 and #47. Findings include: I. Facility policy and procedure The Psychotropic Medication Use policy, revised October 2022, was received by the nursing home administrator (NHA) on 3/20/24 at 9:41 a.m. It read in pertinent part, When psychotropic medications are ordered, the interdisciplinary team (IDT) identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non-pharmacologic and pharmacological interventions. Licensed nurse obtains informed consent for the use of psychotropic medications. II. Resident #31 A. Resident status Resident #31, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included dementia, insomnia, anxiety and major depressive disorder The 12/18/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Record review (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan, initiated on 12/27/23, revealed the resident took antidepressant medication related to her diagnosis of major depressive disorder. The interventions included giving antidepressant medications as ordered and educate the resident about the risks, benefits and side effects and/or toxic symptoms of antidepressant drugs to be given. -The care plan failed to identify the resident received antidepressant medication daily (Trazodone) to treat her insomnia. The March 2024 CPO revealed the following orders: -Trazodone 100 milligrams (mg), one tablet by mouth at bedtime for insomnia. Ordered on 1/2/24. -Vortioxetine 20 mg, one tablet by mouth one time a day for major depressive disorder. Ordered on 9/12/23. -A review of Resident #31's medical record failed to reveal an informed consent had been obtained from the resident or the resident's representative for the administration of the Trazadone or Vortioxetine. C. Staff interviews The director of nursing (DON) was interviewed on 3/19/24 at 12:42 pm. She said she was not aware the consents for psychotropic medications for Resident #31 had not been obtained. She said it was the responsibility of the nurse to obtain consent from the resident when the medication was ordered. The DON said she was new to her position and would follow up to obtain the consents from the resident. The social services director (SSD) was interviewed on 3/20/24 at 9:05 a.m. She said she audited resident medical records monthly during psychopharmacological meeting but was unsure why Resident #31 did not have signed consents for the ordered antidepressant medications. 46022 III. Resident #47 A. Resident status Resident #47, age 86, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dementia with behavioral disturbance, anxiety and depression. The 2/24/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. B. Record review The March 2024 CPO revealed the following orders: -Zoloft Oral Tablet 47 mg by mouth one time a day for depression, ordered 10/13/23. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lorazepam Oral Tablet 0.5 mg, give 0.5 mg by mouth two times a day for anxiety, ordered 1/19/24. -Seroquel Oral Tablet 25 mg, give one tablet by mouth two times a day for depression with psychosis, ordered 3/5/24. -A review of Resident #47's medical record failed to reveal an informed consent had been obtained from the resident or the resident's representative for the administration of the Zoloft, Lorazepam and Seroquel. C. Staff interviews The SSD was interviewed on 3/19/24 at 12:19 p.m. The SSD said the nursing staff was responsible for obtaining consent for the use of psychotropic medications. The SSD said she was aware Resident #47 did not have consent forms for the use of three psychotropic medications. Licensed practical nurse (LPN) #4 was interviewed on 3/19/24 at 1:46 p.m. LPN #4 said the nurse who completed the resident's admission was responsible for obtaining consents for psychotropic medications. LPN #4 said if the physician ordered a new psychotropic medication after the resident was admitted to the facility it was the nurse who was on duty at the time of the new order to obtain a consent from the resident or resident's representative. The DON was interviewed on 3/19/24 at 3:07 p.m. The DON said it was the nursing department's responsibility to obtain consents prior to the use of psychotropic medications. The DON said she was aware that Resident #47 did not have consents for the use of three psychotropic medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on interviews, observations and record review, the facility failed to ensure resident choices for two (#25 and #17) of three residents reviewed for activities of daily living out of 34 sample residents. Specifically, the facility failed to: -Ensure Resident #25 and Resident #17 received showers consistently according to their choice of frequency; and, -Ensure Resident #25's preferences were included in her plan of care. Findings include: I. Facility policy and procedure The Bath, Shower, Tub policy, revised February 2018, was received from the nursing home administrator (NHA) on 3/20/24 at 12:42 p.m. It read in pertinent part, Notify the supervisor if the resident refuses the shower/tub bath. Report other information in accordance with facility policy and professional standards of practice. II. Resident #25 A. Resident status Resident #25, age 89, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included polyneuropathy (nerve pain), dementia, squamous cell carcinoma of skin (skin cancer), psoriasis (autoimmune disease affecting the skin and joint disorder). The 12/7/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score of 14 out of 15. She required set-up assistance for eating, oral hygiene and dressing. She required supervision assistance for toileting, showering and personal hygiene. B. Resident interview Resident #25 was interviewed on 3/13/24 at 3:24 p.m. Resident #25 said she preferred to take showers on Saturday mornings. Resident #25 said Saturdays worked best for her schedule. Resident #25 said she preferred female caregivers to help her with her showers. Resident #25 said she did not like when male caregivers were able to see her naked. She said showers were a private time for her. Resident #25 said the facility had not asked her what her shower preferences were. C. Record review (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated on 9/14/23, revealed the resident needed assistance with dressing, personal hygiene and bathing due to her diagnosis of dementia. Resident #25 was able to perform most activities of daily living with minimal assistance. The interventions included in pertinent part: providing bathing on Mondays and Thursdays. -A review of the resident's comprehensive care plan revealed the care plan did not address Resident #25's current shower preferences. A review of the point of care documentation in the residents medical record indicated her shower days were Mondays and Thursdays. -The point of care documentation did not indicate the resident preferred female caregivers. Licensed practical nurse (LPN) #4 was interviewed on 3/19/24 at 3:04 p.m. LPN #4 revealed the shower binder at the nurses station documented the residents shower days were Wednesday and Saturday. -The shower binder at the nurses station and the point of care documentation did not match or meet the preferences of the resident. C. Staff interviews LPN #4 was interviewed on 3/19/24 at 3:04 p.m. LPN #4 said Resident #25's shower days were on Wednesday and Saturday according to the shower book that was kept at the nurses station. LPN #4 said she was not aware that Resident #4 preferred female caregivers. LPN #4 said she was unsure how each resident's shower preferences were obtained. Certified nurse aide (CNA) #11 was interviewed on 3/19/24 at 4:28 p.m. CNA #11 said she was not familiar with Resident #25's shower preferences. CNA #11 said she would look at the shower book and the point of care system to determine Resident #25's preferences. -However, the shower book and the point of care system did not match and did not indicate the resident preferred female caregivers. The director of nursing (DON) was interviewed on 3/19/24 at 3:07 p.m. The DON said a resident's shower preferences should be obtained upon admission and reviewed regularly. The resident's preference should also include if they prefer a male or female caregiver. The DON said she was not sure what Resident #25's shower preferences were. The DON said the resident's shower preferences should be included on the resident's plan of care and in the point of care system where staff document when showers were completed. 48112 III. Resident #17 A. Resident status (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17, age greater than 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dementia, ischemic cardiomyopathy (decreased ability to pump blood), chronic kidney disease, heart failure and gout. The 1/2/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. He required substantial assistance with showering. He had no behaviors or rejections of care. B. Observation On 3/13/24 at 12:11 p.m., Resident #17 was in the dining room next to his room. His hair was sticking straight up and had not been combed. He was partially bald and his hair was approximately three inches. The front of his long sleeved shirt had a white stain in the middle of the shirt. C. Record review The resident's Kardex (tool utilized by staff to help provide consistent care of residents), reviewed on 3/20/24, revealed Resident #17 preferred a male staff member for showers and his preferred shower days were Tuesdays and Saturdays in the evening. He required one staff member and maximum assistance with bathing. The ADL care plan, initiated on 7/15/22 and revised on 10/12/23, revealed Resident #17 had a self care performance deficit related to dementia and weakness. Pertinent interventions included he required one staff participation in maximum assistance with bathing. -The care plan did not document the resident preferred male staff for bathing. Review of Resident #17's shower records from 2/19/24 to 3/20/24 revealed he had received three showers and refused three showers. -The refused showers revealed the staff were female, despite Resident #17's preference for male staff members for showers. D. Staff interviews CNA #3 was interviewed on 3/19/24 at 3:56 p.m. CNA #3 said she knew which residents needed a shower based on the unit's shower book and Kardex. She said Resident #17's preference was to shower in the evening. CNA #3 said she did not know Resident #17 preferred a male staff member for showers. She said if a resident had a preference for a male staff member for showers, she would ask a male nurse who worked at night to give the resident his shower. The DON was interviewed on 3/19/24 at 3:09 pm. The DON said a resident's shower preference was determined at the time of admission. She said the evaluation determined if the resident wanted a shower or bath, a male or female staff member for bathing, time of day, how many times a week and what time of day the resident wanted to bathe. The DON said CNAs could look at the Kardex to determine a resident's bathing preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said CNAs should document all attempts to shower a resident in the resident's electronic chart. She was not aware of Resident #17's preferences for bathing. She did not know why he only had three showers in the past 30 days. She said if a resident preferred a male staff member for personal care the female staff members should find a male staff member to perform the care. She said Resident #17's unit did not have a lot of male nurses and CNAs who worked on the unit.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

41032

Based on record review and interview, the facility failed to ensure all grievances were followed up on and resolved timely and appropriately.

Specifically, the facility failed to make prompt efforts to resolve resident and resident representative grievances about a variety or concerns including:

-Provision of timely care;

-Responding to resident call lights;

-Ensuring competent staff;

-Ensuring agency staff performed care services as assigned;

-Ensure a resolution to the resident's complaint about poor care and services; and,

-Maintain evidence of the result of all grievances.

Findings include:

I. Facility policy and procedures

The Grievances/Complaints, Filing Policy, revised April 2017, was provided by the nursing home administrator on 3/20/24 at 11:41 a.m. It read in pertinent part: Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.

All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.

Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint. The grievance officer, administrator and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. The administrator will review the findings with the grievance officer to determine what corrective actions, if any, need to be taken.

The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The administrator, or his or her designee, will make such reports orally within ___ (this line was left blank/ the number of days was not documented in the facility policy) working days of the filing of the grievance or complaint with the facility. b. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. II. Resident group interview Four alert and oriented residents (#63, #88, #33 and #4) who usually attended the resident council and were interviewed on 3/18/24 at 1:00 p.m. The residents all discussed how unhappy they were with the agency staff the facility had contracted to provide resident care. The group said the agency certified nurse aides (CNAs) were not oriented or trained on the expectations to provide resident care. Agency staff did not know how to operate the facility's call light system and they did not respond positively or timely to requests from residents for care assistance. The group said each time they got an agency staff responding to provide their care they had to train the staff themselves on how to perform their care and meet routine care requests in line with the established care plans because agency staff appeared to be unaware of their individualized care need. The group members said they often went without proper care due to the agency staff's lack of knowledge or unwillingness to perform their jobs appropriately. III. Resident interviews Resident #63 was interviewed on 3/19/24 at 9:21 a.m. She said the call lights did not work properly and/or they were not answered in a timely manner. She said she pushed her call light on 3/18/24 at 7:20 p.m. and staff did not answer her call until 8:30 p.m. She said sometimes her wait was longer. Resident #63 said she believed that the majority of the problem was the amount of agency staff that the facility used. She said the majority of all shifts were staffed with agency staff and they were not invested in providing good care in a timely manner. Resident #63 said that when an agency staff responded to provide care, she had to train the staff on how to respond and inform them of her care needs because they did not seem to have been trained properly to be able to provide good care. The staff were not responsive and timely to requests for care assistance. Resident #63 said she had talked with another resident in the facility and they told her agency staff were not providing good care to them either. Resident #63 said she had filed numerous complaints about the quality of care from agency staff but does not believe that the facility is taking grievance complaints seriously and has done little to resolve the numerous complaints they have received about nursing care and agency staff. Resident #88 was interviewed on 3/19/24 at 10:47 a.m. Resident #88 said management should focus on call light response times as that was a big problem in addition to providing agency staff with better training because there should be a higher work ethic for all staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #88 said the quality of care received and how quickly a call light gets answered depended on what time of day he needed assistance. Most of the agency staff hired just do not care and if no one was watching them most agency staff do not make the effort; they provide bad care and we have to wait a long time to receive that bad care. Resident #88 would like facility management to pay closer attention to the call lights and staff response to the resident's requests for care assistance. Resident #88 would like to see management staff hold agency staff accountable for providing good care and not have the resident be subject to poor care and service before they do something about the problem. Resident #33 was interviewed on 3/19/24 at 11:00 a.m. Resident #33 said evening shift call lights were not answered timely the response time averaged 45 minutes. The evening shift was mostly staff with agency CNAs who did not know her care needs, preferred routines or methods of care. Resident #4 was interviewed on 3/19/24 at 11:24 a.m. Resident #4 said the agency staff worked mostly evenings and nights and they were not prompt about answering call lights. Resident #4 said a good response time was 10 minutes; however, when agency staff were working she had to wait approximately 30 to 40 minutes for them to answer her call light and there were times when she went without care assistance well into the night because he staff did not respond to her call light at all. Resident #4 said it took two CNAs to transfer her in and out of bed and she said she needed her legs propped on a pillow at bedtime. She said the agency staff did not know how to do those things for her and she was often uncomfortable due to the agency staff's lack of knowledge or training on her specific care needs. Resident #4 said the agency staff needed to be trained properly so the residents received appropriate care. Resident #4 said she wanted the facility to hire more permanent staff so the residents did not need to explain to every new CNA how they should be providing competent care. Resident #63 was interviewed on 3/20/24 at 4:05 p.m. Resident #63 said she had filed several grievance reports with the same concerns about poor nursing care and response on several occasions and the facility continued to fail to address the root cause of her and similar concerns of her peers also living in the facility. Resident #63 said the facility used way too many agency staff who were poorly trained, had a bad attitude and bedside manner and then failed to hold those staff accountable to provide quality care. The resident said she chose this facility for its past reputation but lately, there had been so much turnover in leadership that no one was taking responsibility for ensuring the residents of the facility were receiving competent and quality care. Resident #63 said she was second guessing her decision to move into the facility. IV. Record review A request was made for a resident grievance concerns regarding nursing care from December 2023 to March 2024, 50 grievances were provided. A sampling of the grievance reviewed documented the following resident concerns. A resident grievance, filed on 12/7/23, revealed that an agency CNA performing an improper mechanical list caused her pain and discomfort in her foot. Resident #4 said the agency CNA was argumentative and disrespectful when she asked the CNA to change her approach to assisting her in a transfer with a mechanical lift. Per the resident, when she asked the staff to change her approach the CNA argued with her and told the resident she was the one who needed to be more respectful and not talk to staff in that tone. The facility responded by placing the agency CNA on a do not return status. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There were no other actions taken. A resident grievance, filed on 12/13/23, revealed an agency nurse was rude to a resident while administering a bedtime medication. The complainant said the nurse was impatient and rushed the resident through the medication administration process. Then when asked to leave the door open the nurse closed the door in a harsh manner. The facility responded to place the agency nurse on a do not return status. -There were no other actions taken. A resident grievance, filed on 12/22/23, revealed the resident activated his call light for staff assistance to get changed but no one answered his call light. The resident had to go down the hall to the nurse's station where three CNAs and a nurse were having a conversation and ask directly for staff to assist him with his care. The facility educated the CNAs that they needed to answer resident call lights and informed the resident/complainant that it was hard to educate agency staff who were not there on a regular basis. -There were no other actions were taken. A resident grievance, filed on 12/22/23, revealed one of the two agency staff on duty did not have a good bedside manner and everyone was upset with the scheduling of so many agency staff. The facility talked to the resident/complainant and explained that it was difficult to educate agency staff who were not there on a regular basis. -There were no other actions taken. A resident grievance, filed on 12/25/23, revealed that an agency was rough and non-caring and the resident/complainant and another resident did not want that CNA in their room again. The facility responded by placing the agency CNA on a do not return status. -There were no other interventions. A resident grievance, filed on 12/27/23, revealed that when a resident requested an accommodation based on preferred medication administration times and was told by the unit manager that nursing staff could honor that request. After the arrangements were documented, the nurse on duty told the complainant that she did not need her medications at that time. The facility's response included documentation that the resident's schedule was already in place and that staff knew the resident's actual preferred times. -There were no actions taken. A resident grievance, filed on 12/28/23, revealed the resident activated her call light and waited for two hours, the CNA did not respond. When the nurse on duty arrived to give the resident their medication three hours late the resident confronted the nurse and the nurse responded by telling the resident she did not like how she (the nurse) was binge-treated by the resident. The facility educated the nursing staff to answer call lights and administer medication timely and be respectful to the residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Six separate resident grievances, filed on 12/29/23, revealed two residents had requested CNA #8 not be assigned to their care due to the CNA not providing care when they asked for assistance and when the CNA provided services she was rough with care. The facility educated the CNA. -There were no other actions taken to ensure the CNA was acting appropriately towards residents. A resident grievance, filed on 1/5/24, revealed an agency CNA put the resident to bed earlier than desired and was rude throughout the care process. After being put to bed the CNA would not speak to the resident. The resident feared retaliation for filing the grievance. The facility held an additional resident council meeting to discuss nursing concerns (see below). A resident grievance, filed on 1/9/24, revealed the resident asked for staff assistance to get dressed for bed and put on his pajama pants. The CNA threw the pajamas at the resident and told the resident to do it himself. When the grievance coordinator investigated the resident then responded to questioning that it only happened once and he was thankful for the other CNAs helping him. -The facility took no actions to address the resident initial grievance /complaint. A resident grievance, filed on 1/9/24, revealed a resident complaint about CNA turnover. The resident said facility staff were familiar with her routine and meeting her care needs. -The grievance form did not document if there were any actions taken to address the resident's grievance concerns. A resident grievance, filed on 1/10/24, revealed a resident complaint her medications were administered two and a half hours late because the agency nurse did not have access to the computerized medication administration record (MAR). -The grievance form did not document if there were any actions taken to address the resident's grievance concerns. The 1/31/24 resident council minutes revealed old business discussions included: poor call light responses. The previous director of nursing (DON) said agency staff were provided written instructions on how to use the call light system. Resident were encouraged to continue to use their call lights to request assistance. The DON said she would continue to educate staff and requested the resident to report concerns. Call light concerns were unresolved. New Business: The NHA started doing spot checks of the call lights systems and addressing staff directly. The NHA reported that the facility was making progress but the concerns were still a work in progress. Residents asked what was the reasonable timeline. The State would like the response to be 15 minutes at most; the NHA would like to get it a lot less. A resident grievance, filed on 1/22/24, revealed a resident activated his call light to request staff assistance to use the bathroom. A CNA responded and rudely told the resident I do what I want to do and slammed the resident door shut without helping the resident use the bathroom. The resident waited an hour and a half for staff to come and provide care and ended up urinating in his brief. The resident said this was not the first time he had problems with this CNA. The facility's response to the grievance was to interview the resident and when the resident said I think the staff are trying. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mountain Vista Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4800 Tabor St Wheat Ridge, CO 80033	

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no further action taken. A resident grievance, filed on 2/1/24, revealed a resident complained that she pressed her call light for staff assistance to get ready for and to go to bed. After waiting an hour and a half no staff responded to her call light so she started yelling for help, eventually, staff went to assist the resident with care and assist her to bed. The facility updated the resident care plan. -No further action was taken. A resident grievance, filed on 2/25/24, revealed a resident had to refile grievance concerns about long call light wait times, poor nursing care and poor medication time management because the resident's concerns were not addressed the first time she filed the grievance/complaints. The facility told the resident concerns were unresolved due to leadership turnover and said they would continue to follow up and communicate with her until her concerns were resolved. A resident grievance, filed on 3/5/24, revealed when the resident complained of being uncomfortable during the showing process and the CNA laughed and said you just lie to complain. The resident asked that the named CNA not be assigned to assist him with care in the future. The facility changed the CNA's assignment and the DON was to meet with the CNA prior to the CNA's return to work. -There was no documentation if the DON ever met with the CNA or what was discussed with the CNA. V. Staff interviews The staff development coordinator (SDC) was interviewed on 3/19/24 at 10:45 a.m. The SDC said the facility was actively recruiting nursing staff but relied heavily on agency CNAs and licensed nurses to meet the needs of residents in the facility. Each agency staff were to read the contents of the binder before starting work and sign an acknowledgment of understanding the contents of the binder. The binder contained information on the mission and vision of the facility, confidentiality, communication, directions for logging into and documenting resident care in the resident electronic medical record and operating and responding to resident call lights. The SDC said the CNA leaving shift would give report to the CNA common on shift. While the CNAs did their best to provide a thorough report the CNAs leaving shift may forget to pass some information along. The SDC said all agency staff had access to the resident's medical records so they could check car plan information if needed. The DON was interviewed on 3/19/24 at 4:00 p.m. The DON said the goal was to hire staff and reduce the use of agency staffing so that the facility could fully train their own staff and hold them accountable for providing quality care to the residents. The DON said the facility had a problem with staff answering call lights timely and consistently because the call lights did not always work properly. Staff had a hard time turning off the call lights once activated, due to a functional issue. When a call light was alarming the staff had a habit of thinking that it was already answered and they did not go back to check on the residents. The DON said the CNA should return to the resident's room to check on the resident and not leave the room until they successfully deactivated the call light. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said she was not sure what training agency staff received prior to starting their shift but knew they were supposed to get a status report on each resident on the reassignment before starting work from staff leaving shift. The DON said if agency staff were not providing appropriate care or not performing to the facility's standards the agency staff was placed on a do not return list. 42193

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review, observations and interviews, the facility failed to ensure two (#17 and #72) out of two residents out of 34 sample residents were free from involuntary seclusion. Specifically, the facility failed to ensure Residents #17 and #72 who resided in the secured unit, had the required assessment to justify such restrictions. Findings include: I. Facility policy The Wandering and Elopement policy, revised March 2019, was received by the nursing home administrator (NHA) on 3/20/24 at 12:42 p.m. It read in pertinent part: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. -A policy for secured unit placement was requested but not received by exit on 3/20/24. II. Resident #17 A. Resident Status Resident #17, age greater than 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included dementia, ischemic cardiomyopathy (decreased ability to pump blood), chronic kidney disease, heart failure and gout. The 1/2/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. He had an impairment on one side of his upper extremities and an impairment on both sides of his lower extremities. He used a manual wheelchair. He required supervision for oral hygiene and toileting, He required substantial assistance with showering. He required moderate assistance with dressing. It indicated that the resident did not exhibit any behaviors during the assessment period. The resident wandered during the assessment period. B. Observations During a continuous observation on 3/18/24 starting at 11:53 a.m. and ending at 1:13 p.m., Resident #17 did not wander or display any exit seeking behavior. The resident remained in his wheelchair. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation starting at 3:10 p.m. and ending at 4:11 p.m., Resident #17 did not wander or display any exit seeking behavior. The resident remained in his wheelchair. C. Record review The cognition and dementia care plan, revised 4/11/23, revealed the resident would likely experience a progressive decline in intellectual functioning characterized by a deficit in memory, judgment, decision making and thought process. The intervention was to utilize approaches that maximize involvement in daily decision making and activity. The psychosocial well-being care plan, revised 8/17/23, revealed the resident's psychosocial well-being may be impacted due to changes in living environment, loss of independence, extreme hearing loss, depression, general anxiety and loss of cognition. The resident was potentially at risk for negative social interactions due to a lack of social awareness of removing himself from escalating social situations. The intervention was to discuss beliefs, values, and cultural traditions significant to the resident and provide opportunities for the resident to follow when possible. The risk for wandering and elopement care plan, created and revised on 2/9/24, revealed the goal was for the resident to not leave the facility unattended and the resident's safety would be maintained. The interventions created and revised on 2/9/24 included increasing awareness and monitoring from staff, engaging resident in purposeful activity, evaluation for secured placement, family discussions for secured unit placement, identifying if there was a certain time of day for wandering and elopement attempts, identifying if there was a pattern for purposeful wandering, identify wandering and elopement de-escalating behaviors, provide care in a calm and reassuring manner, provider clear and simple instructions and provide reorientation to surroundings and environment. -The resident's electronic medical record did not reveal that the facility identified a certain time of day for wandering and elopement attempts. The resident's electronic medical record did not reveal that the facility identified a pattern for purposeful wandering. The facility did not identify wandering and elopement de-escalation behaviors. -The care plan was not revised when the resident moved to the secure unit on 2/22/24. The 6/18/23 elopement assessment documented the resident should be considered to be at risk for elopement if they score or higher. Resident #17 scored a four out of 10, which indicated the resident was a risk for elopement. It said the resident had a history of leaving the facility without informing staff, and expressed the desire to go home, the resident's behavior was likely to affect the safety or well-being of self or others, and wandering behavior was a pattern and goal directed. The suggestions were to monitor location frequently, use check-in and check out log, document specific behavior on the behavior log, review current medication regime and notify staff of elopement and wandering risk. -The resident's electronic chart revealed there were no elopement attempts between 6/18/23 and 2/7/24. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/7/24 at 2:30 p.m. elopement incident report was reviewed. It revealed the resident exited the building by the front door and walked approximately 10 feet down the front pathway. The receptionist had eyes on him the entire time. The resident said, I wanted to go home. The immediate action was that the resident was encouraged to return to the building. The resident was agreeable to returning. -The incident report did not identify predisposing environmental factors, physiological factors and situational factors. The incident report revealed the resident's power of attorney was not notified. The 2/7/24 at 3:07 p.m. the elopement incident report was reviewed. It revealed the resident exited the building by the front door and walked approximately 10 feet down the front pathway. The receptionist had eyes on him the entire time. The resident said, I went out for a breath of fresh air.The immediate action was that the resident was escorted to his room. The resident had a sitter until further steps were established. -The incident report did not identify predisposing environmental factors, physiological factors and situational factors. The incident report revealed the resident's power of attorney was not notified. The 2/7/24 nurse progress note from 4:38 p.m. documented the nurse was notified by the front desk that the resident was sitting outside with the receptionist. The resident told the nurse he was lost and wanted a bus to go to a casino and then home. An hour later, the nurse was notified by the receptionist that the resident left again. The resident was brought back inside. The director of nursing (DON) and the resident physician were notified. The resident was checked every 15 minutes; the resident remained in the dining room. The 2/7/24 nurse progress note from 4:46 p.m. documented that the DON wanted the 15-minute checks to stop and be replaced with a one-on-one sitter for the resident. The 2/8/24 provider progress note revealed the resident had exit seeking behavior last night. The resident attempted to leave the building and was confused about where he was. He was not on antipsychotics. The resident could move to a secured unit. The resident's power of attorney (POA) was notified to discuss reintroducing antipsychotic medication and/or moving to the secure unit. The resident's POA mentioned new environments were difficult for the resident. The provider's plan was to wait for lab results and monitor for further behaviors. The 2/9/24 provider progress note revealed there was no exit seeking behavior by the resident since last night. The resident was agitated and restless last night. The POA was notified to reconsider Seroquel if the resident had increased aggression or continued to exit seek. The 2/9/24 elopement evaluation documented the resident had a history of attempting to leave the facility without informing the staff, expressed the desire to go home, had a wandering behavior that was a pattern and goal directed. The resident's behavior was likely to affect the safety or well-being of self or others The suggestions were to monitor location frequently, utilize check-in and check log, document specific behaviors on the behavior log, review current medication regime and notify staff of elopement and wandering risk. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/9/24 secured unit placement admission team evaluation was reviewed by the facility's executive director, director of nursing, social services staff member and an assisted living facility's executive director. The assisted living facility's executive director was not a social worker and did not have a background in behavioral health. The power of attorney signed the evaluation on 2/22/24. The evaluation said the resident was at risk of wandering away from a familiar setting with the inability to find his way home. -The evaluation did not document if the resident had a significant behavioral health issue that seriously disrupted the rights of other residents, was at risk of danger to self or others, and what the less restrictive alternatives attempted and why such alternatives were unsuccessful in preventing harm to self or others. The 2/13/24 nurse progress note revealed the resident did not have exit seeking behaviors. There was no indication to move the resident to the memory care unit. The one on one sitter was discontinued and the resident was placed back on 15-minute checks. The 2/22/24 social services note summarized a care conference meeting with the POA, dietary services, nursing services and social services director (SSD). The note documented that the resident had two elopement attempts. The facility explained to the POA the rationale for moving the resident to the secured unit. The family was in agreement. The POA discussed the resident's preference to go outside, enjoy looking out the windows and other personal preferences to ensure success on the secured unit. The 2/26/24 provider progress note revealed the resident was at baseline, calm and pleasant. The March 2024 MAR was reviewed. There were no physician orders to monitor for elopement and wandering. III. Resident #72 A. Resident status Resident #72, age greater than 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included vascular dementia, muscle weakness, anxiety, depression and dysphasia (swallowing difficulty). The 12/14/23 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. He had an impairment on one side of his upper extremities and an impairment on both sides of his lower extremities. He used a manual wheelchair. He required substantial assistance with personal hygiene, oral hygiene, toileting, and dressing. He was dependent for showering. He required substantial assistance in mobility, including rolling left to right, sitting to lying and lying to sitting on the side of the bed. He was dependent to sit to stand and bed to chair transfers. The assessment revealed that the resident did not exhibit any behaviors during the assessment period. The resident wandered during the assessment period. B. Observations (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 3/18/24 starting at 11:53 a.m. and ending at 1:13 p.m., the resident did not wander or display any exit seeking behavior. The resident remained in his wheelchair. During a continuous observation on 3/18/24 starting at 3:10 p.m. and ending at 4:11 p.m., the resident did not wander or display any exit seeking behavior. The resident remained in his wheelchair. C. Record review The psychosocial well-being care plan, initiated on 7/5/23, revealed the resident's psychosocial well-being may be impacted due to a change in living environment, loss of independence and loss of cognition. Interventions included encouraging socialization, monitoring for changes in mood and offering choices to promote a sense of independence, well-being and self-worth. The mood care plan, revised on 7/10/23, revealed the resident's coping was impaired due to anxiety, depression, and depression. The interventions included administering medications and assessing medication effectiveness. Additional interventions included encouraging the resident to reminisce about his life, encouraging socialization with others, encouraging supportive visits and if the resident appeared upset, unable to relax or yell at staff, encouraging the resident to verbalize needs and feelings. The cognition/dementia care plan, revised on 7/10/23, revealed the resident was likely to experience a progressive decline in intellectual functioning characterized by a deficit in memory, judgment, decision making and thought process related to dementia. The interventions included accessing family as needed, encouraging residents to voice needs, providing reminders and cues as needed and identifying self and what care was provided. The communication care plan, initiated on 2/17/21 and revised on 7/10/23 revealed the resident had communication deficits related to change in environment and routine. The interventions included inviting his power of attorney to his care conferences, observing and assessing for secure unit placement as needed and if a resident attempted to go into other rooms or leave the unit, showing the resident where his room was. The staff should attempt to meet his needs and distract him by providing him with reading materials, coloring materials and talking to him. Reassure residents that his power of attorney knows where he is. The secured unit care plan, initiated on 7/10/23 and revised on 10/9/23, revealed the resident demonstrated actions that warrant placement in a secured unit by recommendation of his primary care provider. Without appropriate oversight, the resident could pose a threat to himself or others. The intervention was to re-evaluate every 180 days to establish the resident still met the criteria to be in the secured unit. The impaired cognition care plan revised on 10/5/23, revealed the resident had impaired cognitive function related to the diagnosis of vascular dementia. The interventions included administering medications as ordered, using task segmentation to support short-term memory deficits and reviewing medications to report possible causes of cognitive medications. The depression care plan, revised on 10/5/23, revealed the resident used an antidepressant medication. The interventions included giving medications as ordered and monitoring signs and symptoms of depression. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/15/23 interdisciplinary note revealed the resident was moved to the secure unit. The 5/22/23 social services progress note revealed the resident moved to the secure unit. The 5/23/23 secure unit placement admission evaluation was determined to be at risk for wandering from a familiar setting with the inability to find his way home, at risk of danger to self and less restrictive alternatives have been unsuccessful in preventing harm to self. -There was a note on the secured admissions evaluation from the POA documenting that they were not part of the secured placement admission evaluation team meeting. The POA wrote that the resident did not have a significant behavioral health issue that seriously disrupts the rights of other residents. The POA indicated the resident was not at risk of danger to others. The 5/24/23 nurse progress note revealed the resident went to different rooms and tried to open the door with his feet. The resident was easy to redirect. The 6/21/23 social services progress note revealed the resident experienced signs and symptoms of depression. The provider ruled out clinically related concerns regarding change. The change was discussed with the interdisciplinary team on how to support the resident. The 6/22/23 nurse progress note revealed the resident called another resident a pig. He was disturbed by his roommate and another resident who yelled all day. He was sad and angry all day. The recommendation was to move the resident to another room. He had exit seeking behavior. He kicked the front door with his legs. He was redirected. His appetite was poor. The 7/26/23 nurse progress was note revealed the resident was agitated when he received activities of daily living care. He hit and kicked the staff. The 10/18/23 secure unit placement admission evaluation revealed the resident was determined to be at risk for wandering away from a familiar setting with the inability to find his way home and at risk of danger to himself or others. The 12/8/23 elopement evaluation documented that the resident did not have any elopement and wandering behavior and did not have suggested interventions or consider if the resident's placement in the secured unit continued to be appropriate. The 1/16/24 180-day review secure unit placement evaluation revealed the resident was determined to be at risk for wandering away from a familiar setting with the inability to find his way home. The March 2024 MAR did not document a physician's order to monitor for elopement and wandering and revealed the resident did not exhibit any behaviors. IV. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/19/24 at 3:56 p.m. She said residents were in the secure unit because they had Alzheimer's. She said the residents tried to go home because they wanted to see their family or children or due to their behavior. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 said she was familiar with Resident #72 and Resident #17. She said Resident #72 had been in the secured unit for the past two weeks. She said he wanted to do his own thing. She said he liked to drink coffee and eat sweets like donuts. She said he liked to participate in activities, watch a movie and sit at the end of the unit to watch cars drive by the facility. Before he moved to the secured unit, he liked to be in the dining room because there was a bird cage and he liked to see the birds. She said he was not combative nor did he try to leave the secured unit. CNA #3 said Resident #17 was combative around agency staff because the agency staff did not know him and that made him combative. She said if the staff explained to the resident what they were trying to do, he did not exhibit any behaviors. She said if residents exhibited any exit seeking behaviors she documented in their electronic medical records. Licensed practical nurse (LPN) #2 was interviewed on 3/20/24 at 11:13 a.m. She said residents were in the secure unit for different reasons. Some residents were admitted to the secure unit straight from their home because there was a safety concern and sometimes residents were admitted to the secured unit from another unit in the facility. When an internal move occurred there should be a physician's order prior to moving a resident to the secured unit. LPN #2 said the purpose of a secured unit was to keep the resident from physical harm and prevent elopement and exit seeking. She said staff were to monitor resident activities based on the resident's identified behaviors. If a resident was exit seeking, staff would monitor if they were wandering and/or trying to leave the facility. LPN #2 said it was important for an assessment of the resident to be completed prior to the move to the secured unit so the staff knew what to monitor for and knew how to ensure the resident remained safe. She said it was important to have the resident's family/POA involved in decision making because they knew the resident best. LPN #2 said she was familiar with Resident #72. She said Resident #72 was in the unit because he started to wander out of the facility. She did not see the resident show any exit seeking behaviors from the resident and she did not get a report from other nurses working on the unit that the resident was actively exit seeking. LPN #2 said Resident #72 enjoyed participating in activities programming; liked to watch television, exercise and liked to talk to other residents and staff. LPN #2 said she was familiar with Resident #17. She said Resident #17 was admitted to the facility in 2021 from an assisted living and was recently admitted to the secure unit because he had exit seeking behaviors and wandered in other resident's rooms. She said he liked to do therapy and participate in activities. She did not see the resident show any exit seeking behaviors since he moved to the secured unit. The director of nursing (DON) was interviewed on 3/19/24 at 3:09 p.m. She said the residents were placed in the secure unit because the residents attempted to exit the facility or the residents tried to hurt themselves. She said a physician was needed to determine if a resident should be placed in a secured unit. She said if the resident eloped, that was not a reason in itself to place a resident in a secured unit. She said an evaluation should be completed prior to placement. She would check to see who should be part of the evaluation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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F 0603

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The DON said it was important for an evaluation to be completed to show that the resident was placed in a secured unit based on behaviors for their safety. She said staff knew a resident was a high risk for elopement based on observation and documentation of those behaviors in the resident's medical record.

The DON said a periodic reassessment for secured placement needed to be completed to determine if the resident demonstrated the behaviors were at the same level at time of initial assessment or if the behaviors improved or worsened. The DON was new to her position in the last few days and said she would have to look up the frequency of the secured unit reassessments.

The DON said if the resident did not demonstrate elopement, behaviors or a threat to themselves or others, the facility should look to move the resident off of the secured unit to a less restrictive placement if assessed to be possible. This would depend on an assessment to determine if the resident was still trying to elope, wanted to go home or go shopping or hallucinating.

The DON said she was not familiar with Resident #72 or Resident #17. She said a resident's care plan should have been in place to show what interventions were attempted prior to the move to the secured unit.

She reviewed the provider note for Resident #72. She said the decision was to try medications to reduce behaviors or place the resident in the secured unit.

The social services director (SSD) was interviewed on 3/19/24 at 4:18 p.m. She said residents were placed in the secure unit because they were a risk to themselves or if they wondered.

The SSD said the interdisciplinary team (IDT) were part of the evaluation process. She staff knew a resident was a high risk for elopement based on the care plan and secured unit assessment.

The SSD said a secured unit placement reassessment was required every 180 days but the facility did it quarterly. She said the behaviors monitored in the secure unit depended on the resident's actions.

The SSD said she was familiar with Resident #17. She said he was found in places in the facility that he should not have been in. She said he was generally a pleasant resident and was not exit seeking. She said the resident used to be a lot busier and roamed around. The resident declined medically and physically and the staff no longer needed to redirect the resident because he did not wander. She said some residents would be determined to leave the secured unit.

The SSD said that based on Resident #17's current behavior, it would be appropriate to re-evaluate his secured unit placement to see if he should transfer out of the secured unit.

The SSD said that Resident #17's family did not have involvement in the plan to move the resident to the secured unit and the POA was not consulted properly. She said the placement to move the resident to the secured unit happened over the weekend without the family's consent. She said the family came to the facility and did not know that the resident had been moved.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said she was familiar with Resident #72. She said he just moved to the secured unit after two elopement attempts where he was easily redirected to go back to the facility. She said the family was resistant to Resident #72 move to the secured unit because they thought the move would take his freedom away and they knew how much he enjoyed being in the dining room and around familiar staff and residents. She said the facility initiated a one-on-one sitter but the sitter was removed because he was not showing any exit seeking behavior and it was unrealistic to have a sitter for the long term. Instead, the IDT recommended the resident move to the secured unit because he was assessed to be an elopement risk. The SSD said the facility did not have a wander management system such as a wander guard for residents who were at risk for elopement. The facility did have door alarms on the facility doors when they were locked in the evening from 7:00 p.m. to 7:00 a.m.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48112

Based on observation, record review and interviews, the facility failed to ensure one (#72) out of 34 sample residents with limited range of motion received appropriate treatment and services.

Specifically, the facility failed to ensure preventative measures were put in place for Resident #72's hand contracture.

Findings include:

I. Facility policy and procedure

The Restorative Nursing Services policy and procedure, revised July 2017, was received by the nursing home administrator (NHA) on 3/20/24 at 12:42 p.m. It read in pertinent part:

Residents will receive restorative nursing care as needed to help promote optimal safety and independence.

Restorative goals may include, but are not limited to supporting and assisting the resident in:

adjusting or adapting to changing abilities; developing, maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence and self-esteem; and participating in the development and implementation of his/her plan of care.

II. Resident #72

A. Resident status

Resident #72, age greater than 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included vascular dementia, muscle weakness, anxiety, depression and dysphasia (swallowing difficulty).

The 12/14/23 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He had an impairment on one side of his upper extremities and an impairment on both sides of his lower extremities. He used a manual wheelchair. He required substantial assistance with personal hygiene, oral hygiene, toileting and dressing. He was dependent for showering. He required substantial assistance in mobility, including rolling left to right, sit to lying, and lying to sitting on the side of the bed. He was dependent to sit to stand and bed to chair transfers.

The resident did not have occupational or physical therapy during the review period. He had three out of seven days of active range of motion.

B. Observations

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/24 at 11:12 a.m. Resident #72 was in the dining area. The resident had a left hand contracture. He did not have a brace, splint or other assistive device on his hand. From 11:53 a.m to 1:13 p.m. Resident #72 was near the front door of the secured unit. At 12:22 p.m. the resident was assisted to the first dining table closest to the nurse's station. The resident had a left hand contracture. He did not have a brace, splint or other assistive device on his hand. From 3:10 p.m. to 4:11 p.m. Resident #72 was in his wheelchair in the dining area. The resident had a left hand contracture. He did not have a brace, splint or other assistive device on his hand. C. Record review The restorative range of motion care plan, revised on 3/12/24, revealed the resident required active range of motion due to muscular weakness, vascular dementia. He was at risk for decline in mobility due to the disease process of dementia and increased weakness and coordination. Interventions included an active range of motion program. The restorative splint care plan, revised on 2/15/24, revealed the resident had a splint that needed to be worn six to eight hours through day or night. Interventions included staff assistance to place blue hand splint on the left hand each morning and replace with white splint at night. The March 2024 treatment administration record (TAR) was reviewed. It revealed the following: -Left hand resting forearm splint (blue splint) on from 7:00 am. To 9:00 p.m. Notify the restorative nurse if the resident removes at night. Start 5/26/23. On 3/19/24, it was documented that the splint was off. -Left hand soft white finger separator/splint. On before bed and take off in AM. Notify the restorative nurse if the resident removes at night. Start 5/25/23. On 3/2/24, 3/3/24, 3/4/24 and 3/9/24 the MAR documented the splint was off. -The resident's electronic chart revealed there was no documentation why the splint was off. -The resident's electronic chart revealed there was no documentation that the restorative nurse was notified when the splint was removed. There was no documentation that the resident refused to wear the splint. III. Staff interviews The director of nursing (DON) was interviewed on 3/19/24 at 3:09 p.m. She did not know the contracture management program for hand contractures. She said interventions used in a contracture management program were exercise, physical therapy and rolled towels in between the fingers and palm of the hand. She was not familiar with Resident 17's contracture plan. She said a splint was used to prevent the contracture from worsening. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 3/20/24 at 11:13 a.m. She said the restorative contracture plan for Resident #17 was to have a left hand splint from 7:00 a.m. to 9:00 p.m. The unit nurse or restorative nurse was responsible for putting the splint on and off. He wore a different brace at night. She knew he wore the splint when she did her assessment and she documented he wore his splint in the resident's TAR. She said he wore a brace to prevent his contractures from worsening. The restorative nurse was interviewed on 3/20/24 at 12:41 p.m. He said the contractures management program for hand contractures included splints, brace and a rolled washcloth between the fingers and palm of the hand. He said the restorative contracture plan for Resident #17 was to wear a hand splint six to eight hours a day. The goal was to decrease the edema. He wore a blue splint during the day and a white splint during the night. The certified nurse aide (CNA) and nurse were responsible for ensuring the splint was worn. The CNA knew Resident #17 needed to wear a brace and the nurse knew the resident needed to wear a brace by reading the care plan. The CNA documented in the electronic chart and the nurse did not document it. Resident #17 wore the brace to prevent the contracture from worsening. He was not aware the resident did not wear the splint on 3/19/24. He said the contracture program was based on the resident's tolerance level. The staff should not force the resident to wear it. If the brace was off, they should find out why it was off. IV. Facility follow up The facility followed up on 3/22/24. It documented the hand splint was documented as off in the TAR per the instructions in the order and the hand splint was removed. In addition, the CNA staff helped to perform his splint restorative program. This meant an effort that the staff attempted to continue to apply the splint. The resident had the right not to wear the splint and it was documented in the TAR that the splint was off. He wore a different splint during the night, which the documentation showed for the date in question. Based on the TAR, the resident wore his splint regularly with assistance from staff. The restorative nursing splint assistance program documentation provided by the facility on 3/22/24 documented the CNAs to place blue hand splint on the left hand each morning and replace with white splint at night. On 3/19/24, documentation showed CNAs did something at 1:47 p.m. and 3:10 p.m. -There was no documentation that the resident refused to wear the splint or why the splint was not on the resident's hand.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to two (#87 and #92) of three residents reviewed received the care and services necessary to meet their nutritional needs and maintain their highest physical well-being level out of 34 sample residents. Resident #87 was admitted on [DATE]. Her admission weight was 113.8 pounds (lbs). The resident maintained a weight between 113 lbs and 118 lbs between January 2023 and January 2024. The resident lost 12.3 pounds between 1/4/24 and 2/15/24. The facility did not weigh the resident monthly despite a physician's order for monthly weights. The registered dietitian (RD) recommended weekly weights and weights were not consistently obtained on a weekly basis. The resident had poor meal intake and refused meals. There were no preventative measures implemented to address her eating patterns to ensure her intake was adequate. Due to the facility's failure to implement nutritional interventions, Resident #87 sustained a severe weight loss of 10% or 11.7 pounds in six months. Resident #92 was admitted on [DATE]. Her admission weight was 152 lbs. The resident maintained a weight between 147.3 lbs and 153.2 lbs between 5/12/23 and 2/6/24. Weekly weights and weights were not consistently obtained on a weekly basis. There were no nutritional interventions implemented between 2/6/24 and 3/3/24 when she sustained a 15.1 lbs weight loss. Due to the facility's failure to implement nutritional interventions, Resident #92 sustained a severe weight loss of 17.36% or 26.6 pounds in six months. Findings include: I. Facility policy The Nutritional Assessment policy, revised October 2017, was received by the nursing home administrator (NHA) on 3/20/24 at 12:42 p.m. It read in pertinent part, The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. The Weight Assessment policy, revised March 2022, was received by the NHA on 3/20/24 at 12:42 p.m. It read in pertinent part, Resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

II. Resident #87

A. Resident status

Resident #87, age [AGE] years old, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included prediabetes, osteoporosis, abnormal weight loss, major depressive order, vascular dementia with behavioral disturbance, atherosclerosis of native artery, chronic obstructive pulmonary disease and gastro-esophageal reflux disease (GERD).

The 1/17/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The resident required set up assistance for eating. She required substantial assistance with oral hygiene, personal hygiene, toileting and showering.

The assessment documented the resident required set up assistance with eating and the resident had not experienced weight loss. Her height was 4 feet 11 inches and she weighed 116 pounds. Her diet was a mechanically altered diet.

B. Observations and interview

The resident was in the dining area of the secured unit on 3/13/24 from 12:11 p.m until 12:46 p.m. She required complete assistance with her meal. She consumed less than 25% of her meal.

On 3/18/24 the resident was in her room due to contact isolation measures. The nurse brought the resident lunch at 12:41 p.m. The nurse left the room at 1:09 p.m. The nurse said the resident ate about 25 percent of her meal. The nurse said the resident did well with a nutritional supplement shake and liquids but not the actual meal. The meal intake record documented she consumed less than 25% of her meal.

C. Record review

Resident #87's weight loss history revealed significant weight loss as follows:

-On 10/5/23, the resident weighed 116.3 pounds;

-On 11/6/23, the resident weighed 118.3 pounds;

-On 12/2/23, the resident weighed 117.8 pounds;

-On 1/4/24, the resident weighed 116.3 pounds;

-On 2/15/24, the resident weighed 104 pounds;

-On 2/23/24, the resident weighed 103.6 pounds;

-On 3/1/24, the resident weighed 108.3 pounds;

-On 3/18/24, the resident weighed 103.2 pounds; and,

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 3/19/24, the resident weighed 104.6 pounds. Resident #87's medical record revealed she experienced a significant unplanned weight loss of 10% or 11.7 pounds in six months from 10/5/23 to 3/19/24. The nutrition care plan, revised 1/22/24, revealed the resident had nutritional risks and potential for nutrition risks related to weight loss, dementia, psychotic disturbance, anxiety, hypothyroidism, prediabetes, osteoporosis, glaucoma, poor mobility and elevated LFT's (liver function tests). Interventions included encourage food and fluids at and between meals, honor food preferences, offer snacks daily, occasionally could feed self but usually required increased cueing and assistance at meals, monitor labs, weights, fluid volume status and skin integrity, provide supplements as ordered and monthly weights. The malnutrition care plan, revised 1/29/24, revealed the resident was at risk for malnutrition. The interventions included a complete mini nutritional evaluation, if malnourished consult dietitian and if mini nutritional evaluation results indicate risk, consult dietitian. The dementia care plan, revised on 1/27/23, revealed the resident would likely experience progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to dementia. Interventions included a BIMS at each review or as needed to monitor for changes in cognition. The self care deficit, revised 1/29/24, revealed the resident was at risk for feeding. The interventions included to provide meal support per resident's need The 2/22/24 dietitian progress note revealed she was not sure the 2/15/24 weight was accurate and changed monthly weights to weekly weights. The 2/28/24 dietitian progress note revealed the resident's weight was down significantly since December 2023. It read in pertinent part, The resident's intake declined. Increased frequency of Ensure supplement. Possible effect by norovirus? Noticeable decrease intake and nausea. Continued weekly weights and relay concerns to nursing and social services. The 3/7/24 dietitian progress note revealed the resident was on weekly weights. The note documented in pertinent part, Weight on 2/23/24 was 103.4 pounds. Variable intake through February (2024). No nausea, vomiting or diarrhea per progress notes. Follow weekly weights. The 3/8/24 nurse progress note for weekly weights said that weight was not obtained because weight was not due. -There was no documentation that the physician or dietitian were notified that the weight was not obtained. The 3/18/24 nurse progress note revealed the provider was notified about a new weight. The resident was already on Ensure (nutritional supplement), modified diet, recent illness and poor appetite. The provider ordered labs. The dietitian was notified and followed up once labs were completed. The resident was not experiencing difficulty with swallowing or a modified diet. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The 3/19/24 dietitian progress note (during the survey) revealed the resident had significant weight loss since December 2023. The note documented in pertinent part, She declined medically since January 2024. She had increased temperature. Pneumonia was ruled out with chest x rays. Fluids were encouraged. She was in isolation due to an outbreak of norovirus but remained asymptomatic. Resident was weak, poor intake and temperature. Concerned with the resident's overall medical decline, advanced age, severe dementia and weight loss. Body mass index (BMI) decreased from 23.9 to 20.8. May consider hospice consultation if warranted. Continue weekly weights and supplements. The March 2024 CPO revealed the following: -Regular puree textured diet -Ensure plus, three times a day for poor intake. Offer after meals, 237 mls. Start 2/28/24. -Ensure plus, one time a day for poor intake and weight loss. Start 10/20/23, discontinued 2/28/24. -Give snacks at bedtime. Start 3/15/23. -Weigh weekly, one time a day every 7 days. Start 2/23/24. -The facility did not follow the weekly weight order between 3/1/24 and 3/17/24. -The Ensure supplement was not changed until 2/28/24, after the resident had lost 12.7 lbs since 1/4/24. The March 2024 meal intake records documented the resident consumed the following from 2/19/24 to 3/20/24. The records revealed the resident ate 76-100 percent on 20 occasions, 51-75 percent on seven occasions; 26-50 percent on 21 occasions, zero-25 percent on 20 occasions and refused five meals (3/11/24, 3/13/24, 3/15/24 and 3/19/24). The resident had less than three meals in a day recorded for several days from 2/19/24 to 3/20/24. The record revealed the resident ate two meals on six days (2/20/24, 3/6/24, 3/9/24, 3/14/24, 3/16/24 and 3/19/24) and only one meal on five days (2/22/24, 2/29/24, 3/1/24, 3/7/24 and 3/17/24). III. Resident #92 A. Resident status Resident #92, age [AGE] years old, was admitted on [DATE]. According to the March 2024 CPO, the diagnoses included dementia, Alzheimer's, psychotic disturbance, mood disturbance, general anxiety disorder and osteoarthritis. The 2/15/24 MDS assessment documented that the resident had severe cognitive impairment with a BIMS score of zero out of 15. The resident required partial assistance for oral hygiene, toileting, showering, dressing and personal assistance. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The assessment documented the resident required partial assistance with eating and the resident had not experienced weight loss. and had experienced weight loss. Her height was 5 feet 4 inches and she weighed 147 pounds. She was on a mechanically altered diet. B. Observations and interviews The resident was observed on 3/13/24 from 12:11 p.m until 12:54 p.m. An unidentified certified nurse aide (CNA) and an unidentified nurse talked at 12:28 p.m. The CNA said the resident lost 20 pounds. The nurse went to the medication cart and came back to the resident with a shake in a plastic cup. The resident tried to drink the shake independently. Her hand was shaking and she almost spilled the shake. The shake was not reoffered. The CNA provided juice in a plastic cup and left the resident. The resident spilled the juice when the CNA walked away. C. Record review Resident #92's weight loss history revealed significant weight loss as follows: -On 9/7/23, the resident weighed 153.2 pounds; -On 10/5/23, the resident weighed 151.6 pounds; -On 11/6/23, the resident weighed 152.7 pounds; -On 12/7/23, the resident weighed 150.6 pounds; -On 1/4/24, the resident weighed 151.5 pounds; -On 2/6/24, the resident weighed 147.3 pounds; -On 3/3/24, the resident weighed 132.4 pounds; -On 3/13/24, the resident weighed 126.6 pounds; and, -On 3/19/24, the resident weighed 131.4 pounds. -Despite the 15.1 pounds (10.12%) weight loss demonstrated in one month between 2/6/24 and 3/3/24, the facility did not add any nutritional interventions until ten days after the significant weight loss was documented. Resident #92's medical record revealed she experienced a significant unplanned weight loss of 17.36% or 26.6 pounds from 9/7/23 to 3/13/24. The nutrition care plan, revised 2/19/24, revealed the resident was at risk related to dementia, seasonal allergies, B12 vitamin deficiency, constipation and vitamin D deficiency. Interventions included encourage food at and between meals, Ensure twice a day, honor food preferences, offer snack daily, weekly weights, monitor labs and could sometimes eat independently but may need full assistance. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The dementia care plan, revised 5/24/23, revealed the resident would likely experience progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to dementia. Interventions included simplify tasks by breaking tasks into one step at a time and utilize approaches to maximize involvement in daily decision making and activity. The ADL self care performance deficit care plan, revised 5/25/23, revealed the resident had a deficit related to dementia. She was able to hold the cup, feed herself and eat foods independently. The eating care plan, revised 8/28/23, revealed the resident had her own teeth with some missing teeth. She was able to feed herself independently, follow staff set up, encouragement and cueing. Interventions included staff to provide set up assistance with feeding. Staff were to provide verbal cues, set up tray, pour liquids, cut foods and apply condiments with each meal. The 3/18/24 provider note documented Resident #92 was seen for gradual weight loss of 25 pounds over the past 12 weeks and six pounds over the past three weeks. Staff reported she often did not eat well, took two to three Ensures daily and took fluids with encouragement. Her weight loss was expected and unavoidable as her dementia advanced. The dentist was following for a tooth that periodically became abscessed, though it did not seem to interfere with her eating or cause pain. The staff should continue oral intake and supplementation as tolerated. -The provider had called the weight loss unavoidable, however, there were no interventions added when she had a significant weight loss from 2/6/24 to 3/13/24. In addition, the resident had an abscessed tooth that did not interfere with eating, however according to the dietitian's note (see below) she had poor appetite due to the abscessed tooth. The 3/16/24 nurse progress note revealed the resident was losing weight and had declined. The resident ate 100% at breakfast, lunch and dinner. The 3/15/24 nurse progress note revealed the resident was physically declining and failed to thrive. It documented in pertinent part, Resident stayed in bed and encouraged fluids. Ensure ordered for two times a day. Resident was weak and left message for provider for labs. The 3/15/24 dietitian progress note (during the survey) documented the resident was treated for weight loss. It documented in pertinent part, Resident started on Ensure twice a day. Resident refused to drink. Resident has poor appetite due to abscess on right side of face. The 3/13/24 dietitian progress note said the resident was treated for tooth abscess with oral antibiotics. The resident had decreased in oral intake over the last week. Requested resident was reweighed because weight was significantly down. Added oral supplement for calories and fluids. Resident did well with finger foods and needs cueing and encouragement with intake. Follow weights weekly. The 3/12/24 provider notes revealed the staff reported right sided facial swelling due to an abscessed tooth. The resident did not open her mouth. She had a slight right sided facial swelling with palpation. She refused to open her mouth for an oral exam and did not show any signs of pain when palpating. The plan was to continue with antibiotics and probiotics. The 3/8/24 social services note revealed a request for a dental appointment as soon as possible. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-There was no documentation that a dentist saw the resident. A request for dental records was made and the previous dentist visit from 11/14/23 was provided. The medication administration record (MAR) was reviewed for March 2024. It revealed the following orders: -Monthly weights on the third of every month. Start 3/3/24. -Weekly weights; one time a day every seven days for weekly weights. Start 3/14/24. -Ensure plus three times a day. Offer three times a day. Offer after meals. Start 3/14/24. -Give snack at bed time. Document percent eaten. Start 5/12/23. -Clindamycin 150 mg. Take one capsule by mouth every six hours for abscess for five days. Take one tablet every six hours for five days followed by dentist visit. Start 3/7/24. The March 2024 meal intake records documented the resident consumed the following from 2/19/24 to 3/20/24. The records revealed the resident ate 76-100 percent on 45 occasions, 51-75 percent on eight occasions; 26-50 percent on 13 occasions, zero-25 percent on two occasions and refused four meals. The resident had less than three meals in a day recorded for several days from 2/19/24 to 3/20/24. The record revealed the resident ate two meals on seven days (2/20/24, 3/6/24, 3/9/24, 3/14/24, 3/16/24, 3/17/24 and 3/19/24) and only one meal on four days (2/22/24, 2/29/24, 3/1/24 and 3/7/24). IV. Staff interviews CNA #3 was interviewed on 3/19/24 at 3:56 p.m. She knew when to weigh a resident when the nurse provided a list and verbally told the CNA. She said the list was for residents who lost weight. Once she weighed the resident she told the nurse. She documented the weight in the resident's electronic medical record. She asked the nurse what the resident weighed the last time the resident was weighed. She said it was important to weigh a resident because it showed the resident's health status. CNA #3 said she was familiar with Resident #87. She did not know why the resident lost weight because she ate her pureed meal and she required assistance with meals. CNA #3 said she was familiar with Resident #92. She said the resident ate a lot at dinner but she did not eat as much at breakfast and lunch because she was sleeping. The director of nursing was interviewed on 3/20/24 at 12:49 p.m. She said she was not familiar with Resident #87 and Resident #92. She said all residents should be weighed at least monthly. She said it was important to monitor the resident's weight because if the resident lost weight it could indicate the resident was depressed or the resident did not like the food or consistency. She wanted to pay more attention to the resident and add interventions to prevent weight loss. She said the nursing staff collaborated with the dietitian to ensure weights were completed. The nurse told the CNA to weigh the resident. The nurse was responsible to notify the dietitian when the resident had weight loss. The dietitian was notified in a daily meeting. The DON was unable to say what defined significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The unit manager (UM) was interviewed on 3/20/24 at 12:59 p.m. She said there was an issue with staff weighing residents as ordered. She said some staff did not like the scale in the unit where Residents #87 and #92 lived. She said there was not oversight to ensure weights were obtained based on the physician orders. She said the facility corrected the issue. The dietitian shared a list of residents who required weekly weights. The registered dietitian (RD) was interviewed on 3/20/24 at 10:06 a.m. She was responsible for completing the nutritional assessment and they were completed at time of admission, quarterly and if there was a change in condition. She was notified when a resident lost weight during a morning clinical meeting, if a provider notified her and she independently looked through a dashboard connected to the resident's weights on a weekly basis. She said significant weight loss was five percent in 30 days, seven and half percent in a quarter and more than ten percent in six months. She said interventions depended on the resident. If they did not like fluids, she would not add a liquid supplement. She would add a powder supplement to mashed potatoes or soups to increase calories. She tried liquid supplements. She wanted the liquid supplement to be administered when medications were administered. She tried different supplements if a resident only liked a specific flavor or if there was a supply issue. She added weekly weights as another intervention. She talked to speech therapy if the resident was on a pureed diet to see if the resident could move to a mechanical diet. She considered double portions for women if they had assistance at meals. She said double portions for elderly women was hard because the quantity was overwhelming. She considered changing from one supplement to another supplement if the resident had weekly weights and took 50% or less of the supplement. The RD said weekly weights were an intervention because it was an easy way to see an improvement or a decline. The first time a resident lost weight, she asked the staff to re-weigh in case the scale was not accurate. The nurse or nurse manager was responsible for notifying the family and the provider. If she was familiar with the family, she would notify them. She said the restorative program was responsible for weighing residents but in February 2024, the CNAs took over. She said CNAs did not do weekly weights. She would make requests but it did not happen. She sent lists to the DON. She said February 2024 was difficult because if she did not have the resident's weights, she was unable to do quarterly assessments or change in condition assessments. The RD said Resident #87 was always a good eater. She saw the resident's weight loss in February 2024. She was not notified in February 2024 that the resident was not eating well. She added weekly weights for the resident. She said the staff might not have weighed the resident because the scale the staff used regularly was in a different unit. The unit Resident #87 resided on was in an outbreak and staff might not have wanted to use the scale in the other unit. She was not sure why the resident was not eating in the past seven days. She said the resident was accepting the liquid supplements. She wanted the resident to gain one to two pounds a week. She was surprised the resident lost weight so she asked for a new weight. She said she would ask the kitchen to add more mashed potatoes to her meals. -However, mashed potatoes were not implemented based on the care plan and the RD's documentation (see above). The RD said Resident #92 required total assistance with her meals. She was not notified the abscess bothered the resident. If she was notified about the abscess she considered a downgrade in her diet so the food was easier for the resident to eat. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The medical director (MD) was interviewed on 3/19/24 at 11:48 a.m. He said when a resident lost weight, he looked to see if the facility provided food that the resident liked, if food was given in a timely manner, where the resident ate and if the resident needed assistance. He looked at medical issues to see if there were medications that suppressed the resident's appetite. He checked labs to see if there was another cause of weight loss. He evaluated if the resident would tolerate a medication to stimulate the resident's appetite. He said weekly weights were an important intervention. He said he was unable to speak specifically about Resident #87 and Resident #92. -However many of the interventions the medical director suggested for weight loss were not implemented or tried to prevent the significant weight loss of Resident #87 and Resident #92.

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F 0697 Level of Harm - Minimal harm or potential for 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** 46022 Based on observations, interviews and record review, the facility failed to manage pain in a manner consistent with professional standard of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for two (#25 and #7) of three residents reviewed for pain out of 34 sample residents. Specifically, the facility failed to: -Offer non-pharmacological pain interventions For Resident #25 and Resident #7; and, -Determine an acceptable pain level for Resident #25 and Resident #7. Findings include: I. Facility policy and procedure The Pain Assessment and Management policy, dated October 2022, was provided by the nursing home administrator (NHA) on 3/19/24 at approximately 1:00 p.m. It read in pertinent part, The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: assessing the potential for pain; recognizing the presence of pain; identifying the characteristics of pain; addressing the underlying causes of the pain; developing and implementing approaches to pain management; identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions; and, modifying approaches as necessary. For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, type and severity of pain. Document the resident's reported level of pain with adequate detail (i.e., [NAME] information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. II. Resident #25 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #25, age 89, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included polyneuropathy (nerve pain), dementia, squamous cell carcinoma of skin (skin cancer) and psoriasis (autoimmune disease affecting the skin and joint disorder. The 12/7/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score of 14 out of 15. She required set-up assistance for eating, oral hygiene and dressing. She required supervision assistance for toileting, showering and personal hygiene. The MDS indicated the resident was on a scheduled pain medication regimen, received as needed pain medication or was offered as needed pain medication and did not receive non-medication interventions for pain. The resident said she had occasionally pain, pain made it difficult for her to sleep at night and limited her day-to-day activities. The resident rated her pain level at a 5 on a 1 to 10 scale. B. Resident interview and observations Resident #25 was interviewed on 3/13/24 at 3:24 p.m. Resident #25 said she had a skin cancer legion to her left upper arm. Resident #25 pointed to her arm that revealed a bandage covering an area on her arm. Resident #25 said the area caused her a lot of pain. Resident #25 said the pain radiated up into her shoulder and down her arm. Resident #25 said the facility did not provide any non-pharmacological pain interventions to help with her pain. Resident #25 said she received pain medications which helped alleviate some of the pain. C. Record review The March 2024 CPO revealed Resident #25 had the following physician orders for pain management: -Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligram), give one tablet by mouth every eight hours as needed for pain, give prior to wound care and every eight hours as needed, ordered 10/6/23 and discontinued 3/6/24. -Norco Oral Tablet 5-325 mg, give one tablet by mouth every six hours as needed for pain related to cancer, ordered 3/11/24. -Tylenol Tablet (Acetaminophen), give 650 mg by mouth every four hours as needed for pain, not to exceed three gm (grams) in a 24 hour period, ordered 10/1/23. -The physician order did not specify when to give the Norco Oral Tablet 5-325 mg versus the Tylenol Tablet 650 mg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/3/24 pain assessment and interview documented the resident occasionally had pain. The assessment documented the resident said her pain occasionally affected her sleep, her ability to participate in therapy activities and interfered with her day-to-day activities. The resident rated her pain level as a 6 on a scale from 1 to 10. The resident reported her pain was moderate. The resident had vocal complaints and facial expressions of pain. The resident had pain on her left shoulder where a wound was present. The assessment documented wound dressing changes, bumping the area or touching the area increased the pain. The assessment documented Norco and leaving the area alone help relieve the resident's pain. The resident had a cancer lesion that was causing her pain. The current pain medication regimen was narcotics. The resident received as needed pain medications or was offered as needed pain medications and declined. The resident received non-medication interventions for pain which included relaxation techniques and distraction. The resident said she knew she could get a pain pill when she wanted it but forgot to ask sometimes. -The pain assessment failed to identify an acceptable level of pain for the resident. The pain care plan, initiated on 9/1/23, revealed the resident had acute and chronic pain. The intervention was to utilize non-medication interventions for pain relief. -A review of the resident's EMR did not reveal documentation of person-centered non-pharmacological pain interventions or documentation that non-pharmacological pain interventions were attempted. A review of Resident #25's January 2024 medication administration record (MAR) (1/1/24 to 1/31/24) documented the resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 rated her pain level as a 0 on 1/5/24, 1/18/24 and 1/19/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 rated her pain level as a 5 on 1/25/24 and 1/28/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when she rated her pain level as a 7 on 1/30/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 rated her pain level at an 8 on 1/30/24 and 1/31/24. A review of Resident #25's February 2024 MAR (2/1/24 to 2/29/24) documented the resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 reported her pain level was a 0 on 2/1/24, 2/9/24, 2/22/24, 2/23/24, 2/24/24 and 2/29/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 reported her pain level was a 4 on 2/25/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 reported her pain level was a 5 on 2/25/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when Resident #25 reported her pain level was a 7 on 2/4/24 and 2/28/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was administered Hydrocodone-Acetaminophen 5-325 mg when she reported her pain level was an 8 on 2/1/24 and 2/20/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when she reported her pain level was a 9 on 2/2/24, 2/6/24, 2/10/24, 2/18/24 and 2/20/24. A review of Resident #25's March 2024 MAR (3/1/24 to 3/18/24) revealed Resident #25 was administered Hydrocodone-Acetaminophen 5-325 mg when the resident reported her pain level was a 4 on 3/1/24. The resident was administered Hydrocodone-Acetaminophen 5-325 mg when she reported her pain level was a 7 on 3/5/24. A review of Resident #25's treatment administration record (TAR) revealed the resident received wound treatment daily. -However, Resident #25 was not administered Hydrocodone-Acetaminophen 5-325 mg daily prior to wound treatment to the cancer lesion on her left upper arm. The resident was only administered the Hydrocodone-Acetaminophen eight of 31 days in January 2024, 15 of 29 days in February 2024 and two of 18 days reviewed for March 2024. A review of Resident #25's March 2024 MAR (3/1/24 to 3/18/24) revealed Resident #25 was administered Norco 5-325 mg when she reported her pain level as a 6 on 3/18/24. The resident was administered Norco 5-325 mg when she reported her pain level was a 7 on 3/11/24. The resident was administered Norco 5-325 mg when she reported her pain level was a 9 on 3/15/24. A review of Resident #25's March MAR (3/1/24 to 3/18/24) revealed the resident was administered Tylenol on 3/6/24 when she reported her pain level as a 5. III. Resident #7 A. Resident status Resident #7, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included anxiety and dementia. The 12/15/23 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required set-up assistance for eating. She required substantial assistance for toileting and dressing. She required supervision for oral hygiene. She was dependent for showering. The MDS assessment indicated the resident was on a scheduled pain medication regimen, did not receive as needed pain medication or was offered as needed pain medication and did not receive non-medication interventions for pain. The resident said she frequently had pain, pain made it difficult for her to sleep at night and limited her day-to-day activities. The resident rated her pain level at a 6 on a 1 to 10 scale. B. Resident interview (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 was interviewed on 3/13/24 at 10:54 a.m. Resident #7 said she had a lot of pain to her upper body, especially her left arm and shoulder. Resident #7 said she received pain medications which helped alleviate some of the pain. Resident #7 said the facility used to provide non-pharmacological pain interventions that helped with her pain but recently have not been offering them to her. She said she enjoyed movement as she used to be an aerobic teacher. C. Record review The March 2024 CPO revealed Resident #25 had the following physician orders for pain management: -Tylenol Tablet (Acetaminophen), give 650 mg by mouth two times a day for pain, not to exceed three gms in 24 hours, ordered 9/17/2020. -Morphine Sulfate (Concentrate) Solution 20 mg/ml (milliliter), give 0.5 ml by mouth four times a day for pain, ordered 5/17/22. -Hydromorphone HCI Tablet 2 mg, give 2 mg by mouth every 12 hours as needed for chronic pain osteoarthritis, ordered 8/10/22. -Morphine Sulfate (Concentrate) Solution 20 mg/ml, give 0.5 ml by mouth every 24 hours as needed for chronic back and shoulder pain, ordered 5/17/22. -Tylenol Tablet (Acetaminophen), give 650 mg by mouth every four hours as needed for pain or fever greater tan 100.4, not to exceed three gm in 24 hour period, ordered 9/16/2020. -The physician order did not specify when to give the Hydromorphone HCI Tablet 2 mg, Morphine Sulfate (Concentrate) Solution 20 mg/ml or the Tylenol Tablet. The 3/15/24 pain assessment revealed the resident frequently had pain. The resident's pain occasionally effected her sleep and frequently affected her day-to-day activities. The resident reported her pain was moderate and voiced complaints of pain. The resident said she had pain daily. The resident had pain to both knees and her left shoulder. The assessment documented weather and movement increased the residents pain. Medications and hot/cold compresses relieved the residents pain. The resident had arthritis and osteoporosis that contributed to her pain. The resident received acetaminophen and narcotics. The resident did not received as needed pain medications or was offered as needed pain medications and declined. The resident had not received non-medication interventions for pain. -The pain assessment failed to identify an acceptable level of pain for the resident. A review of Resident #7's December 2023 (12/1/23 to 12/31/23) MAR revealed Resident #7 was administered as needed Tylenol Tablet 650mg for a pain level of 5 on 2/25/23. Resident #7 was administered as needed Morphine on 12/30/23 for a pain level of 8. A review of Resident #7's January 2024 (1/1/24 to 1/31/24) MAR revealed Resident #7 was administered as needed Tylenol on 2/28/24 for a pain level of 9. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #7's February 2024 (2/1/24 to 2/29/24) MAR revealed Resident #7 was administered as needed Tylenol on 2/19/24 and 2/27/24 for a pain level of 3. Resident #7 was administered as needed Tylenol on 2/20/23, 2/27/24 and 2/28/24 for a pain level of 5. Resident #7 was administered as needed Tylenol on 2/20/24 for a pain level of 5. A review of the resident's medical record revealed the resident's pain was last assessed on 2/29/24. The pain care plan, initiated on 10/9/17 and revised on 10/4/23, revealed the resident was at risk for pain or alteration in comfort related to her diagnosis of osteoarthritis (degenerative joint disease) and chondrocalcinosis (excessive calcium in the bones). The interventions included: acknowledging the presence of pain and discomfort, assessing gastrointestinal status and tolerance to medications, identifying pain location type and raining, promoting relaxation with back-rubs, soft music and reading materials, reporting unrelieved pain to the physician, following up with the pain clinic as needed, administering pain medications per physician orders, providing as needed medications for breakthrough per physician orders and document effectiveness, acknowledging presence of pain and discomfort and implementing relaxation techniques to assist with pain. -A review of the resident's EMR did not reveal documentation of person-centered non-pharmacological pain interventions or documentation that non-pharmacological pain interventions were attempted. IV. Staff interviews Licensed practical nurses (LPN) #4 was interviewed on 3/19/24 at 1:46 p.m. LPN #4 said Resident #25 had pain to her left upper arm. LPN #4 said Resident #25 had a cancer legion that caused the resident pain. LPN #4 said Resident #25 had Norco and Tylenol for as needed pain for Resident #25. LPN #4 said she used her nursing judgment to decide to give Resident #25 the Norco versus the Tylenol. LPN #4 said Resident #25 responded well to distraction as a non-pharmacological pain intervention. LPN #4 said she thought Resident #25's acceptable pain level was a 2 or 3 but was not sure where that was documented in the resident's medical record. LPN #4 said Resident #7 had chronic pain to her left shoulders and knees. LPN #4 said Resident #7 had three as needed pain medications. LPN #4 said she used her nursing judgment to determine which pain medication to administer. LPN #4 said Resident #7 was on Morphine four times a day. LPN #4 said Resident #7's pain needed to be assessed on a numerical level. LPN #4 said the facility was asking and documenting if the resident was in pain and did not assess the resident's pain level daily. LPN #4 said Resident #7 responded well to distraction as a non-pharmacological pain intervention. LPN #4 said she thought Resident #7's acceptable pain level was zero but was not sure where that was documented in the resident's medical record. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/19/24 at 3:07 p.m. The director of nursing (DON) said if a resident had more than one as needed pain medications the physician needed to put parameters in the orders to give the nurse direction on which medication to administer. The DON said it was not within a licensed nurse's scope of practice to determine which pain medication should be administered. The DON said an acceptable pain level for each resident needed to be established and documented in the resident's medical record. The DON said non-pharmacological pain interventions needed to be person centered and included on the care plan. The DON said attempts for non-pharmacological pain interventions needed to be documented in the medical record. The DON said she was not familiar with Resident #25 or Resident #7's pain regimen. The DON said she would review the residents.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on observation, interview and record review, the facility failed to ensure the correct installation, use and maintenance of transfer bar, (fixed bed rail assistive device) for three of three residents (#37 and #42) using bed canes or transfer bars (type of bed rail) for positioning out of 34 sample residents. Specifically, the facility did not ensure resident safety risk when the use of transfer bar/rails were in use, for Residents #37 and #42 by failing to: -Attempt to use appropriate alternatives prior to installing bed rails/transfer bars/rails; -Assess each resident for risk of entrapment from bed rails prior to installation; -Assess and review the risks and benefits of the bed transfer bar assistive device with the resident and or the resident's representative; -Obtain informed consent from the resident and or the resident representative for the use of the assistive device prior to instillation; and, -Ensure periodic assessment of the residents' use of the bed rails after they were installed. Findings include: I. Professional standard The U.S. Food and Drug Administration (FDA) Recommendations for Health Care Providers about Bed Rails, last updated 2/7/23, retrieved on 3/20/24, from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm; the reference included the following recommendations: Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bedside rail, and mattress should leave no gap wide enough to entrap a patient's head or body. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. (continued on next page)

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or water bed.

Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal repeat events can occur within minutes of the first episode.

II. Facility policy and procedure

The Bed Safety and Bed Rails policy, reviewed August 2022, was received by the director of nursing (DON) on 3/19/24 at 1:28 a.m. It read in pertinent part:

Policy interpretation and implementation:

-Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA.

-Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks.

Use of bed rails:

-The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation (IDT), resident assessment, and informed consent.

-If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This IDT evaluation includes:

-An evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs;

-The resident's risk associated with the use of bed rails;

-Input from the resident and/or representative; and,

-Consultation with the attending physician.

-The resident assessment to determine the risk of entrapment includes medical diagnoses, conditions, symptoms and/or behavioral symptoms.

-The resident assessment determines potential risks to the resident associated with the use of bed rails including the following, accident hazards, restricted mobility and psychosocial outcomes.

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following, accident hazards, the resident could attempt to climb over, around, between, or through the rails and a resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress.

-Before using bed rails the staff shall inform the resident or resident representative regarding the benefits and potential hazards associated with bed rails and obtain informed consent.

III. Resident #37

A. Resident status

Resident #37, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included bilateral knee arthritis, hypertension and unspecified convulsions.

The 12/22/23 minimum data set (MDS) assessment revealed the resident was mildly cognitively impaired with a brief interview for mental status (BIMS) score of 13 of 15. The resident was dependent on staff for transfers, required substantial to maximum assistance from staff for showers, dressing and partial to moderate assistance from staff for personal hygiene, bed rolling and for changing positions from sitting on her bed to lying on her bed.

The assessment revealed the resident did not use bed rail physical restraints.

B. Resident interview and observations

On 3/13/24 at 1:45 p.m., Resident #37's bed was observed. The bed was positioned with the left side against the wall and a U-shaped bed cane was attached to the right side upper half of the bed frame. There was no visual gap between the bed cane and mattress, however during a physical assessment, there was a gap of three fingers between the bed cane and the mattress. The bed cane wobbled side to side when inspected.

The resident was interviewed on 3/20/24 at 12:25 p.m. She sat in her wheelchair next to her bed. Resident #37 said she used the bed cane daily and used it to help her lay down on her bed. She said she was aware the bed cane was loose and did not remember if staff checked the bed cane for proper fitting.

During the interview, the resident's spouse sat on Resident #37's bed and then laid on the resident's bed. When he sat down, the mattress compressed his weight and slid towards the wall. When the mattress moved, a gap of three fingers was created between the bed cane and the mattress. Resident #37's spouse said that he liked using the bed cane when he was in her bed and said he used the bed cane to help himself sit up and then stand from the bed. The resident spouse was not a resident of the facility and said he was unaware a gap between the bed cane and mattress was a safety concern.

C. Record review

Resident #37's CPO, dated 12/4/23, revealed the following order: Bed cane-use as directed. No directions specified for use.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #37's record revealed no evidence that Resident #37 was fully assessed/evaluated by the interdisciplinary team (IDT) before using the bed cane. There was a Bed Rail Risk Assessment, dated 9/18/23, completed by the MDS coordinator (MDSC). The assessment read the resident could benefit from quarter side rails to enable bed mobility and assist the resident with repositioning in her bed. -However, a bed cane was ordered instead of the quarter side rail by the physician. -A review of the record revealed no evidence of consultation from the physician for the use of bed rails, when the resident had an increased safety risk due to a medical history of convulsions, documentation of tried and failed alternatives or timely informed consent for the use of the bed cane. The record review revealed on 3/15/24, after the start of the survey, the resident signed a Resident Assistive Device and/or Restraint Consent form. The consent form read the consent was for a right quarter side rail and instead, a bed cane was attached to the right side of her bed. -The consent failed to include Resident #37's applicable medical condition/diagnosis for the bed cane. -The 1/17/24 comprehensive care plan revealed the facility failed to identify why Resident #37 required the bed cane restraint attached to her bed and how it should be used by the resident. IV. Resident #42 A. Resident status Resident #42, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO diagnoses included dementia, vascular Parkinsonism, anxiety and hypertension. The 2/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 of 15. The resident was dependent on staff for transfers, repositioning from lying to sitting in bed, showers and lower body dressing and maximum assistance from staff for upper body dressing, bed positioning, moving from sit to lie in bed. The assessment revealed the resident did not use bed rail physical restraints. B. Resident interview and observations On 3/13/24 at 2:23 p.m., Resident #42's bed was observed. The bed was positioned with the right side against the wall and had bilateral U-shaped bed canes attached to the upper half of the bed frame. When inspected, there was no visual gap, however during a physical assessment, a gap of a fist was present on the left hand side between the bed cane and the mattress. The left hand bed cane wobbled side to side when inspected. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was interviewed on 3/20/24 at 8:55 a.m. She sat in her wheelchair next to her bed. Resident #42 said she did not know why the bed canes were present. She said she did not remember if staff checked the bed cane for proper fitting but was aware there was a gap in the mattress and the bed cane wobbled. She said she thought the bed canes were used to keep her from rolling out of the bed. She said previously rolled out of her bed and was stuck between the mattress and the bed cane and required assistance from a staff member to be freed. C. Record review Resident #42's CPO, dated 4/11/23, revealed the following order: Bilateral bed canes to bed to help increase bed mobility and functional independence. No directions specified for use. -Review of Resident #42's record revealed no evidence that Resident #42 was fully assessed/evaluated by the interdisciplinary team (IDT) before using the bed cane. There was a Side Rail/transfer Bar evaluation, dated 4/10/23. The assessment read the resident could benefit from bilateral bed canes to enable bed mobility for increased functional independence in bed. -The assessment omitted Resident #42's BIMS, diagnoses and ability to understand the risk and use of the bed canes. -A review of the record revealed no evidence of tried and failed alternatives or timely informed consent for the use of the bed cane. -There was no documentation that the IDT completed a reassessment after Resident #42 rolled out on her bed on 12/4/23 and was found by staff entrapped, her left arm wedged between the bed cane and bed mattress. The record review revealed on 3/15/24, after the start of the survey, the resident signed a Resident Assistive Device and/or Restraint Consent form for bilateral bed canes. -The consent failed to include Resident #42's applicable medical condition/diagnosis for the bilateral bed canes. The 2/29/24 comprehensive care plan revealed on 12/8/22 Resident # 42 had a care focus for activities of daily living (ADL) for her self care deficit due to her dementia. On 7/8/22 the ADL care plan read the resident required one-two staff members to reposition and turn in her bed. Care plan interventions included: resident benefits from two u-shaped mobility devised (one on each side) to help increase bed mobility and functional independence. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/23 Resident #42 had a fall. The 12/4/23 fall investigation revealed: resident had an unwitnessed fall in her room. Resident was found sitting on the floor with her back against the bed with her left arm wedged in between the bedrail and the bed mattress, her left leg was laying on the bottom of the side table. Resident #42's description of the fall was 'I am not sure how I got this way, I just rolled over.' The fall investigation dated 12/4/23 at 12:19 p.m. read the resident had injury to her left arm and left hip but injury type was undetermined. Predisposing situation factors read the side rails were up. The physician was notified on 12/4/23. V. Staff interviews The DON was interviewed on 3/19/24 at 12:42 p.m. She said it was the policy of the facility to complete a bed rail assessment prior to attaching bed rails to a bed. She said she did not know who was responsible for completing bed rail assessments and thought it was completed by the social workers. She said once the decision was made to attached bed rails to a resident's bed frame, it was the responsibility of nursing personnel to obtain informed consent from the resident. She said consent could be obtained at the time of admission, or at a later date when the decision was made to use the bed rails. The DON said it was the responsibility of either the unit nurse manager or the MDSC to update a resident care plan to identify the bed rail use directions and intervention. The DON said she was unaware of any occurrences in the facility that involved bed rails. The DON said when bed rails and bed canes were attached to resident bed frames, staff should check the safety of the equipment but was unaware who and when safety checks should be completed. She said she had been the DON for approximately two months. The social services director (SSD) was interviewed on 3/20/24 at 9:05 a.m. She said it was the policy of the facility to complete a bed rail use assessment prior to attaching bed rails to the bed frame. The SSD verified the bed rail assessment was completed by the MDSC on 4/11/23. The SSD said she was unable to locate documentation for Residents #37 and #42 that the facility tried alternatives prior to attaching bed rails/bed canes to their bed. The SSD was unable to locate follow up assessments or IDT documentation that related to the 12/4/23 incident when Resident #42 had been entrapped between the bed mattress and the bed cane. The SSD verified the facility failed to obtain timely consents from Resident #37 and #42 and the consents were obtained after the start of the survey.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41032 Based on staff interviews and record review, the facility failed to ensure licensed nurses and certified nurse aides (CNA) were evaluated for competency and skill sets necessary to care for residents' needs as identified through residents' assessments and care plans. Specifically, the facility failed to have completed competency and skill sets training with licensed practical nurse (LPN) #3 and CNA#4, #5, #6, #7 and #8. Cross-reference to: -F585 failure to resolve resident grievance about agency nursing staff's competency while providing care assistance; -F692 failure to ensure residents received care and services to meet their nutritional needs; -F700 failure to assess and monitor the use of bed rails; and, -F880 failure to implement and practice proper infection control practices during a respiratory syncytial virus (RSV) outbreak. Findings include: I. Facility Policy -A request was made for the facility's policy on assessing nursing staff's competencies, however, the policy was not provided. The In-Service Training, All Staff policy, revised August 2022, was provided by the nursing home administrator (NHA) on 3/20/24 at 11:41 a.m. It revealed in pertinent part: The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. II. Record review On 3/19/24 at 10:32 a.m., a request was made for the staff competencies assessments for five CNAs (#4, #5, #6, #7 and #8) and LPN #3 who were selected at random from all facility hired nursing staff. -The facility was unable to provide proof that any of the selected staff members had been assessed for competency in providing resident care and services. III. Staff interviews (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff development coordinator (SDC) was interviewed on 3/19/24 at 10:45 a.m. The SDC said she was new to the position and was not sure when nursing staff were assessed for competencies. The director of nursing (DON) was interviewed on 3/19/24 at 4:00 p.m. The DON said she was new to her position and had been in the facility for only a couple of days. The DON was unsure of the status of competency assessments for the facility's nursing staff. The NHA was interviewed on 3/20/24 at 1:34 p.m. The NHA said he was not sure when the facility last assessed the competency of nursing staff. The NHA said they had no documentation to show proof that nursing staff, including CNAs and/or licensed nurses, were assessed for competencies in the last 12 months.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46022

Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.

Specifically, the facility failed to:

-Ensure standards of practice were followed for a respiratory syncytial virus (RSV) outbreak in the secured unit were followed;

-Ensure Resident #17, #31, #7, #36 and #11 received the RSV vaccination upon consenting for it; and,

-Ensure the facility had a water monitoring program to prevent the potential spread of Legionella and other waterborne pathogen infections.

Findings include:

I. RSV outbreak

A. Professional reference

The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last reviewed 1/30/2020, retrieved on 4/2/24 from https://www.cdc.gov/handhygiene/providers/guideline.html included the following recommendations, in pertinent part for hand hygiene, Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal.

B. Facility policy and procedure

The Standard Precautions policy, dated September 2022, was provided by the nursing home administrator (NHA) on 31/8/24 at approximately 11:00 a.m. It read in pertinent part, Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents.

Personnel are trained in various aspects of standard precautions to ensure appropriate decision-making in various clinical situations.

After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to residents or environments.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Isolation - Categories of Transmission-Based Precautions policy, dated September 2022, was provided by the NHA on 3/18/24 at approximately 11:00 a.m. It read in pertinent part, Transmission-based precautions are initiated when ar resident develops signs and symptoms of a transmissible infections; arrives for admission with symptoms of an infection; ar has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC (centers for disease control) precaution(s), instructions for use of PPE (personal protective equipment), and/or instructions to see a nurse before entering the room. Signs and notifications comply with the resident's right to confidentiality or privacy. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material. Gloves are removed and hand hygiene performed before leaving the room. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large particle droplets that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). Masks are worn when entering the room. Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions. C. Observations On 3/13/24 at 12:43 p.m. an unidentified staff member went into an isolation room for Resident #17. The staff member did not change the mask before she went into the isolation room. At 12:46 p.m., the same staff member left the isolation room. She did not change masks. There was a sign that indicated the resident was on droplet and contact precautions. The sign documented to remove the face mask prior to exiting the room. During a continuous observation on 3/19/24 beginning at 7:41 a.m. and ending at 9:02 a.m. the following was observed: At 7:42 a.m. licensed practical nurse (LPN) #5 pulled down her mask within six feet of a resident and blew her nose. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Center	4800 Tabor St Wheat Ridge, CO 80033

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 7:43 a.m. certified nurse aide (CNA) #9 exited a resident's room who was positive for RSV with a surgical mask below her nose. CNA #9 did not change her mask upon exiting the room. At 7:48 a.m. CNA #9 began putting on a gown. CNA #9 then reached into her pockets and got a pair of gloves. CNA #9 did not put perform hand hygiene prior to putting on gloves and entered a resident room on isolation for RSV positive. At 7:57 a.m. CNA #9 left the RSV positive room. She removed all personal protective equipment (PPE) in the room except for the surgical mask. CNA #9 did not change her mask upon exiting the room.CNA #9 applied hand sanitizer for six seconds. -However, hand hygiene needs to be completed for at least 15-20 seconds. CNA #9 asked CNA #10 for assistance in the RSV positive room. CNA #9 began putting on a gown and got gloves out of her pocket and put them on. CNA #9 did not perform hand hygiene prior to putting gloves on. CNA #10 put a pair of gloves on and then put a mask on. The room CNA #9 and CNA #10 entered, had a sign on the door that indicated they needed to wear an N95 mask. Neither CNA put on a N95 mask. At 8:03 a.m. LPN #5 pulled her mask down and blew her nose within six feet of residents. LPN #5 applied sanitizer and rubbed her hands together for eight seconds. She then shook her hands in the air to dry them. Her hands were still visibly wet when she began touching the mouse to the medication cart computer. At 8:06 a.m. without performing additional hand hygiene LPN #5 administered a resident his medications. At 8:08 a.m. CNA #9 exited the RSV positive room wearing the same surgical mask. CNA #9 did not change the surgical mask upon exiting the room. At 8:14 a.m. LPN #5 took Resident #17's blood pressure in the dining room. Resident #17 was RSV positive. The licensed nurse did not encourage the resident to go to his room since he was RSV positive. LPN #5 returned the blood pressure cuff to the medication cart without sanitizing the cuff. LPN #5 did not perform hand hygiene. LPN #5 then touched her mask. At 8:15 a.m. Resident #17 entered his room. LPN #5 entered Resident #17's room without PPE and took the resident's pulse. At 8:20 a.m. CNA #9 and CNA #10 began passing out beverages to the residents who were in the dining room. Resident #17 was not encouraged to go to his room to consume his drinks and food. Resident #17 took his mask down near other residents in the dining room and began drinking his coffee. At 8:34 a.m. LPN #5 entered an unidentified resident to administer medications. LPN #5 exited the resident's room and did not perform hand hygiene. LPN #5 touched the mouse to the computer and opened up the medication cart to retrieve medications. At 8:47 a.m. CNA #9 put a gown on and then put a pair of gloves on without performing hand hygiene and entered an RSV positive room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 8:57 a.m. LPN #5 put a gown on and then gloves. LPN #5 did not perform hand hygiene prior to putting on gloves. CNA #10 put on a pair of gloves without performing hand hygiene and then put a gown on. LPN #5 and CNA #10 entered an RSV positive room. At 8:59 a.m. CNA #10 exited the room. CNA #10 applied hand sanitizer and rubbed her hands together for nine seconds. At 9:00 a.m. LPN #5 exited the room. LPN #5 did not change her mask upon exiting the room. LPN #5 left the door open and said Resident #72 was going to come out to the dining room for breakfast. Resident #72 was RSV positive. At 9:01 a.m. the staff assisted Resident #72 to the dining room. D. Staff interviews The infection preventionist (IP) was interviewed on 3/19/24 at 10:27 a.m. The IP said the first resident tested positive for RSV on 3/8/24. The IP said nine residents on the secured unit have tested positive for RSV. The IP said the staff were encouraging residents to stay in their room who were RSV positive or under monitoring for RSV symptoms. The IP said the staff had a difficult time encouraging the residents to stay in their rooms since they had dementia. The IP said LPN #5 and CNA #10 should have not brought Resident #72 to the dining room for breakfast. The IP said the staff knew who was positive for RSV through the report and the end of the shift. The IP said she needed to implement a plan to ensure agency staff were educated on which residents had RSV or were under isolation for RSV symptoms. The IP said she had spoken with the health department and the staff needed to wear a surgical mask, gown and gloves into the RSV positive rooms. The IP said the staff needed to put on the gown then the gloves. The IP said hand hygiene needed to be performed before and after gloves usage. The IP said N95 masks and eye protection did not need to be worn in the RSV positive rooms. She said she needed to review the isolation posting signs in the secured unit to ensure they were all up to date. The IP said the surgical mask that was worn into an RSV room needed to be removed and a new one needed to be worn after exiting an RSV positive room. The IP said hand hygiene needed to be completed after exiting an RSV positive room. The IP said hand sanitizer could be used for hand hygiene. The IP said the staff needed to apply hand sanitizer and rub their hands together until they were completely dry. The IP said it was not appropriate for the staff to shake their hands through the air to dry them. The IP said it was important to ensure their hands were completely dry prior to touching items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP said she had attempted to educate all of the staff prior to the start of their shirts on proper PPE usage and hand hygiene. The IP said LPN #5 was an agency staff member and she had not provided education to her yet. The IP said she called the health department today (3/19/24) to determine the length of isolation needed for RSV. The IP said LPN #5 needed to be away from residents when she removed her mask to blow her nose. The IP said LPN #5 needed to complete thorough hand hygiene after blowing her nose. The IP said the residents who were positive for RSV were on droplet and contact precautions. The medical director was interviewed on 3/19/24 at 11:35 a.m. The medical director said the most important step to reducing the spread of infection was proper hand hygiene. The medical director said the facility needed to notify and educate the staff on which residents were RSV positive. III. RSV immunizations A. Facility policy and procedure The Vaccination Policy-Residents, undated, was provided by the NHA on 4/19/24 at approximately 10:30 a.m. It read in pertinent part, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. B. Resident #17 1. Resident status Resident #17, over the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included dementia, heart failure and chronic kidney disease. 2. Record review -A review of the resident's electronic medical record (EMR) on 3/18/24 revealed the resident had not received the RSV vaccination after the resident's representative consented for the resident to receive the vaccination on 10/18/23. C. Resident #31 1. Resident status Resident #31, age 66, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included fracture of left tibia (leg) and respiratory failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the RSV vaccination after she consented to receive the pneumococcal vaccination on 10/24/23. D. Resident #7 1. Resident status Resident #7, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included anxiety and dementia. 2. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the RSV vaccination after she consented to receive the vacation on 10/24/23. E. Resident #36 1. Resident status Resident #36, age 81, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), heart failure, chronic kidney disease, type two diabetes mellitus and gastro-esophageal reflux disease (GERD). 2. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the RSV vaccination after she consented to receive the vacation on 10/24/23. F. Resident #11 1. Resident status Resident #11, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Alzheimer's disease, morbid obesity and gastro-esophageal reflux disease (GERD). 2. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the RSV after the resident's representative consented for the resident to receive the vaccination on 10/12/23. G. Staff interviews The infection preventionist (IP) was interviewed on 3/19/24 at 10:27 a.m. The IP said she recently started working at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Make sure the program is running as designed (verification) and is effective (validation) -Document and communicate all the activities. Principles: In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for Legionella growth - Preventing water stagnation -Ensuring adequate disinfection -Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. A consultant with Legionella-specific environmental expertise may sometimes be helpful in implementing and operating water management programs. According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, reviewed 2/3/21, retrieved from on 4/1/24: Store hot water at temperatures above 140? and ensure hot water in circulation does not fall below 120?. Recirculate hot water continuously, if possible. Store and circulate cold water at temperatures below the favorable range for Legionella (77-113?); Legionella may grow at temperatures as low at 68?. B. Facility policy and procedure The Legionella Water Management Program policy, revised September 2022, was provided by the NHA on 3/18/24 at approximately 10:00 a.m. It read in pertinent part, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program is reviewed at least once a year, or sooner if any of the following occur: the control limits are consistently not met; there is a major maintenance or water service change; there are any disease cases associate with the water system; or there are changes in laws, regulations, standards or guidelines. C. Record review (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 46022 Based on record review and interviews, the facility failed to establish an infection control program for antibiotic stewardship to include an antibiotic stewardship program. Specifically, the facility failed to have a process in place to track antibiotic usage in the facility. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC), antibiotic prescribing and usage in hospitals and long-term care, dated 2019, retrieved from https://www.cdc.gov/antibiotic-use/core-elements/hospital.html on 4/1/24, included the following recommendations: Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections. II. Facility policy and procedure The Antibiotic Stewardship policy, revised December 2016, was provided by the nursing home administrator (NHA) on 3/18/24 at approximately 10:30 a.m. It read in pertinent part, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes policy, dated December 2016, was provided by the NHA on 3/18/24 at approximately 10:30 a.m. It read in pertinent part, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designess. The IP (infection preventionist), or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. III. Antibiotic tracking system and staff interviews (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IP was interviewed on 3/19/24 at 10:27 a.m. The IP said she was new to her position and recently began working at the facility. The IP said corporate nurse consultant (CNC) #1 and/or CNC #2 would be at the facility until she finished her training. The IP said she was unsure which criteria the facility used for antibiotic stewardship. CNC #2 joined the interview at 11:15 a.m. CNC #2 said the facility used McGreer's criteria for antibiotic use. CNC #2 said the facility used a program embedded into the electronic medical records to track antibiotics. CNC #2 and the IP said they were unsure of which residents were on antibiotics in the facility and if they met McGreer's criteria. CNC #2 said Resident #63 frequently called her physician outside the facility and asked for antibiotics. CNC #2 said the physician could order whatever medications they wanted. The IP said she was unsure how to use the antibiotic tracking system embedded into the electronic medical record. The IP said she found a map used to track infections for February 2024 that CNC #1 had made prior to leaving on vacation. The IP said she would create maps to track infections for January 2024 and March 2024. The medical director was interviewed on 3/19/24 at 11:35 a.m. He said he was not aware that Resident #63 had called her physician outside the facility to request antibiotics. He said he would review the resident's chart and provide education if a physician was providing antibiotics regularly that did not meet criteria.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for five (#17, #31, #7, #36 and #11) of seven residents reviewed for immunizations out of 34 sample residents. Specifically, the facility failed to: -Administer the pneumococcal vaccination after consent was provided for Resident #17, #31, #7 and #11; and, -Document risk versus benefit education for the pneumococcal vaccination for Resident #36. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2022, retrieved on 4/1/24, from: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, in pertinent part, Routine vaccination-pneumococcal-For those ages 19 to 64 with an additional risk factor or another indication was: One (1) dose PCV15 (pneumococcal 15-valent conjugate vaccine PCV15 Vaxneuvance) followed by PPSV23 (pneumococcal 23-valent polysaccharide vaccine PPSV23 Pneumovax 23)or one (1) dose PCV20 (pneumococcal 20-valent conjugate vaccine PCV20 Prevnar 20). For those over the age of 65 who meet age requirements and lack documentation of vaccination, or lack evidence of past infection was: One (1) dose PCV15 followed by PPSV23 or one (1) dose PCV20. Special situations: Age 19-[AGE] years with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: One (1) dose PCV15 or one (1) dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. Note: Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus (HIV), Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies. Note: Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF (cerebral spinal fluid) leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Facility policy and procedure The Vaccination Policy-Residents, undated, was provided by the nursing home administrator (NHA) on 4/19/24 at approximately 10:30 a.m. It read in pertinent part, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. Prior to receiving vaccinations, the resident or legal representative will be provided with information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented in the resident's medical record. All new residents shall be assessed for current vaccination status upon admission. The resident or the resident's legal representative may refuse vaccines for any reasons. If vaccines are refused, the refusal shall be documented in the resident's medical record. III. Resident #17 A. Resident status Resident #17, over the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included dementia, heart failure and chronic kidney disease. The 1/2/24 minimum data set (MDS) assessment indicated the resident was not up to date on his pneumococcal vaccination but did not specify a reason. B. Record review -A review of the resident's electronic medical record (EMR) on 3/18/24 revealed the resident had not received the pneumococcal vaccination after the resident's representative consented for the resident to receive the vaccination on 10/24/23. IV. Resident #31 A. Resident status Resident #31, age 66, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included fracture of left tibia (leg) and respiratory failure. The 3/11/24 MDS assessment indicated the resident was up to date on her pneumococcal vaccination. B. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the pneumococcal vaccination after she consented to receive the pneumococcal vaccination on 10/24/23. V. Resident #7 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #7, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included anxiety and dementia. The 12/15/24 MDS assessment indicated the resident was not up to date on her pneumococcal vaccination but did not specify a reason. B. Record review -A review of the resident's EMR on 3/18/24 revealed the resident had not received the pneumococcal vaccination after she consented to receive the vacation on 10/24/23. VI. Resident #36 A. Resident status Resident #36, age 81, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), heart failure, chronic kidney disease, type two diabetes mellitus and gastro-esophageal reflux disease (GERD). The 2/22/24 MDS assessment indicated the resident was up to date on her pneumococcal vaccination. B. Record review A review of Resident #36's EMR revealed the resident refused the pneumococcal vaccination on 10/24/23. The 10/24/23 communication with resident progress note documented in pertinent part, the resident was offered the pneumococcal vaccination and the resident stated she had already had them and been tested for pneumonia. The resident declined the vaccination. -However, there was no documentation educating the resident on receiving an updated pneumococcal vaccination. VII. Resident #11 A. Resident status Resident #11, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Alzheimer's disease, morbid obesity and gastro-esophageal reflux disease (GERD). The 1/10/24 MDS assessment indicated the resident was not up to date on her pneumococcal vaccination but did not specify a reason. B. Record review (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the resident's EMR on 3/18/24 revealed the resident had not received the pneumococcal vaccination after the resident's representative consented for the resident to receive the vaccination on 10/12/23. VIII. Staff interviews The infection preventionist (IP) was interviewed on 3/19/24 at 10:27 a.m. The IP said she recently started working at the facility. The IP said when residents admitted to the facility their immunization history needed to be researched and documented in the medical record. The IP said the residents needed to be offered the immunizations they needed. The IP said Resident #17, #31, #7 and #11 were offered the pneumococcal vaccination in October 2023 and had not received the vaccination yet. The IP said she was unsure why the residents had not received the vaccination yet. The IP said Resident #36 refused the pneumococcal vaccination because she had already received it. The IP said if the resident was up to date on the pneumococcal vaccination the facility should have not offered the vaccination to the resident. The IP said if the resident was due for an updated pneumococcal vaccination the facility should have provided education to the resident on the importance of the updated vaccination. The IP said she needed to review the CDC guidance on offering pneumococcal vaccinations.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 47536 Based on observations and interviews, the facility failed to maintain emergency response carts equipment in safe operating condition for one out of three emergency carts. Specifically, the facility failed to ensure the emergency response carts were cleaned, maintained and ready for use. Findings include: I. Facility policy The Crash Cart policy statement, undated, was received by the director of nursing (DON) on 3/19/24 at 3:08 p.m. It read in pertinent part, It is the policy of Mountain Vista to standardize the contents of all crash carts and when utilized, provide quality control of all emergency equipment. Policy -Crash carts will be maintained and supplied in accordance with the crash cart minimum requirement list (see list). The list was not provided. -Additional supplies and/or equipment may not be added to the crash cart. -If additional equipment or medications are required by a clinical area, it must be maintained and stored separately. -All emergency equipment and crash carts will be checked minimally weekly on Friday utilizing the crash cart supply list. Procedure for crash carts -Crash carts should be accessible at all times. At least one a week the carts should be opened and checked for outdated supplies. Internal and external equipment should be checked by ensuring proper function of oxygen tank/gauge and suction equipment. -Charge nurses and clinical managers should participate in the weekly checking. -All nurses should be familiar with the cart contents and content locations. -Crash cart checks should be documented on the lists maintained on the cart. II. Observations and interviews (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/24 at 12:28 p.m. the special care unit crash cart was observed with licensed practical nurse (LPN) #1. The crash cart check/signature sheet was stored in the medication cart three-ring binder. LPN#1 verified the daily checks had not been completed for 3/1-3/16/24. The check was completed on 3/17/24 and not for 3/18-3/19/24. LPN #1 said that it was the responsibility of the night shift nurses to check the crash cart nightly for supplies to ensure the emergency equipment was ready for use. The crash cart was covered with debris of food crumbs, dust and hair. LPN #1 said when the crash cart was checked, the cart should also be cleaned ready for use. LPN #1 verified the crash cart contained several miscellaneous items and medical supplies that were not listed on the crash cart inventory list. The crash cart did not include medications (as indicated in the director of nurses interview (see below). III. Administrative interview The director of nurses (DON) was interviewed on 3/19/24 at 12:42 p.m. The DON said she was unsure how frequently the crash cart/emergency equipment cart should be checked by staff. She said crash carts should be checked monthly. The DON then said crash cart checks of the emergency oxygen supply should be done weekly or after it was used and the checks were completed by the pharmacy contractor. The DON said after the crash carts emergency kits were opened or used, the medications were exchanged with the pharmacy.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41032 Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for four of five CNAs (#4, #5, #6 and #7) reviewed for annual training requirements. Specifically, the facility failed to ensure CNAs #4, #5, #6 and #7 received 12 hours of annual training in all required training topics areas including dementia management training and resident abuse prevention training. Findings include: I. Facility policy and procedure The In-Service Training, All Staff policy, revised August 2022, was provided by the nursing home administrator (NHA) on 3/20/24 at 11:41 a.m. It documented in pertinent part, All staff must participate in initial orientation and annual in-service training. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Required training topics include the following: -Effective communication with residents and family (direct care staff); -Resident rights and responsibilities; -Preventing abuse, neglect, exploitation, and misappropriation of resident property including activities that constitute abuse, neglect, exploitation or misappropriation of resident property; procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property; -Dementia management and resident abuse prevention; -Elements and goals of the facility QAPI (quality assurance and performance improvement) program; -The infection prevention and control program standards, policies and procedures; -Behavioral health; and, -The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Training record review Five randomly selected CNA training records were reviewed. Of the five employees reviewed, four CNAs (#4, #5, #6 and #7) did not receive a full 12 hours of annual training and did not receive all of the required training topics. -CNA #4, hired on 3/14/23, had participated in four hours of training during the employee annual training year and had no record of completing dementia management training. -CNA #5, hired on 8/1/22, had no record of completing dementia management training. -CNA #6, hired on 12/8/22, had participated in nine and a half hours of annual training during her first year of employment (December 2022 to December 2023). -CNA #7, hired on 2/9/23, had not participated in any of the required annual training topics and there was no record of CNA #7 completing annual dementia management training and resident abuse prevention training. III. Staff interviews The staff development coordinator (SDC) was interviewed on 3/19/24 at 10:45 a.m. The SDC said the facility staff were assigned training topics and were required to complete all assigned training topics. The director of nursing (DON) was interviewed on 3/19/24 at 4:00 p.m. The DON said the goal of directly hiring CNAs over using agency staff was to ensure staff were fully trained and to hold them responsible for providing competent care. The NHA was interviewed on 3/20/24 at 1:22 p.m. The NHA said nursing staff were assigned specific training modules monthly and were expected to complete the assigned training to work their assigned shifts. The NHA looked for additional training records for the five CNAs reviewed and said the facility had provided all proof of training and competency assessments available. He was unable to locate additional training records to show proof that the CNAs reviewed had completed the required training modules (see training record review above). The NHA said, moving forward, the employees would be required to complete all required training modules or they would be taken off the schedule until they completed their assigned training.