STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065034	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Post Acute	4686 E Asbury Cir Denver, CO 80222

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 38185 Based on record review and interviews, the facility failed to ensure money from personal funds accounts was managed accurately for four (#7, #17, #33 and #39) of four residents reviewed for personal funds accounts out of 39 sample residents. Specifically, the facility failed to notify Residents #7, #17, #33 and #39, who were Medicaid funded, or their legal representative, when the resident's personal funds account reached $200.00 less than the eligibility resource limit for one person. Findings include: I. Record review A copy of residents' personal funds account balances, as of 10/15/24, was provided by the business office manager (BOM) on 10/15/24 at 5:06 p.m. It revealed in pertinent part, -Resident #7 had an account balance of $2,671.23 which was $671.23 over the allotted $2000.00 eligibility limit for Medicaid funded residents.; -Resident #17 had an account balance of $2,585.18 which was $585.18 over the allotted $2000.00 eligibility limit for Medicaid funded residents.; -Resident #33 had an account balance of $3,575.87 which was $1,575.87 over the allotted $2000.00 eligibility limit for Medicaid funded residents.; and -Resident #39 had an account balance of $2,681.23 which was $681.23 over the allotted $2000.00 eligibility limit for Medicaid funded residents II. Staff interviews The BOM was interviewed on 10/15/24 at 4:46 p.m. and again at 5:06 p.m. The BOM said she was responsible for managing the personal funds accounts for the residents at the facility. She said a personal funds account was offered to each resident upon admission and the facility provided account balance statements to residents every quarter. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The BOM said each resident and/or their responsible party was responsible to spend down their account to ensure they did not exceed the allotted Medicaid allowed amount of $2000.00. She said if a resident exceeded the allotted $2000.00, the resident could be at risk of losing their Medicaid status. The BOM said she was aware there were four accounts that were significantly over the allotted $2000.00 Medicaid amount. She said she had just started working for the facility in August 2024. She said the facility had not yet notified the residents and/or their responsible parties about the spend down amounts for Resident #7, #17, #33 and #39. The BOM said she would provide the list to the nursing home administrator (NHA) and get started on the spend down for the residents. The NHA was interviewed on 10/15/24 at 6:00 p.m. The NHA said the BOM was responsible for monitoring the residents' personal accounts to ensure they did not exceed the allotted Medicaid amount of $2000.00. She said if a resident's account exceeded the allotted amount, then the resident could be at risk of losing their Medicaid status. The NHA said she was informed in August 2024 that one resident's account was over the allotted amount, however, she was not aware there were four other residents' accounts that had exceeded the $2000.00 limit. She said she would work with the BOM immediately to contact the residents and their family members to spend down the money.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews and record review, the facility failed to ensure residents were permitted to remain in the facility and not transfer or discharge for one (#76) of two residents out of 39 sample residents. Specifically, the facility failed to provide Resident #76 with an appropriate discharge process. Findings include: I. Facility policy and procedure The Facility-Initiated Transfer or Discharge policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by this facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice to pay for a stay at this facility; or the facility ceases to operate. Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. If the facility does not permit a resident's return to the facility based on an inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. The facility will send a copy of the discharge notice to a representative of the Office of the State Long Term Care Ombudsman. Notice will occur at the same time the notice of discharge is provided to the resident and resident representative. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility. II. Resident #76 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #76, age 65, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), the diagnoses included schizoaffective disorder, bipolar disorder. The 7/8/24 minimum data set (MDS) assessment revealed the resident had short term memory impairment with severe impairment in making decisions regarding daily life. She required supervision or was independent with all activities of daily living (ADL). The assessment documented the resident had hallucinations, delusions, physical behaviors directed toward others, verbal behaviors directed toward others and wandering during the assessment period. The assessment indicated that the resident's return to the facility was not anticipated and active discharge planning had occurred. B. Record review The behavioral care plan, initiated on 7/5/24, documented Resident #76 was verbally aggressive with staff and peers. The resident had a history of calling emergency services if her expectations were not met, declining medication if they appeared different or a different brand from a previous facility, physically hitting another resident and making false accusations. Resident #76 was difficult to redirect when cycling. She yelled and expressed her delusions and hallucinations at herself in the mirror. The interventions included administering medications as ordered, anticipating and meeting needs promptly, documenting and recording behavioral episodes, encouraging the resident to verbalize feelings, establishing a rapport, maintaining a calm, slow and understandable approach, notifying the physician and responsible party of episodes of aggression and abusive behaviors, observing and documenting changes in behavior and potential triggers, observing for clinical factors influencing behavioral indicators, reducing stimuli, and staying calm and composed, avoiding direct eye contact and staring, using short and clear sentences and avoiding any chance for a power struggle. The 6/27/24 behavior progress note documented Resident #76 began speaking over other speakers during a resident meeting with a resident advocate. The facility staff attempted to address the resident's behavior by asking her to hold her comments until the appropriate time, however Resident #76 continued to speak over others, refused to listen and continued to disrupt the meeting. The 7/2/24 behavior progress note documented Resident #76 had provided a personal shopping list to the activity director (AD). Upon asking the resident some questions about the items, Resident #76 became verbally aggressive, repeatedly using profane language, despite the AD attempting de-escalation techniques. The 7/3/24 behavior progress note documented Resident #76 called the police stating that someone had stolen her money. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/5/24 interdisciplinary team (IDT) progress note documented Resident #76 continued to express delusions, disorganized thoughts and speech, chaotic behavior, anxiety, apathy and blank facial expressions. The 7/5/24 IDT note further indicated Resident #76 had been accepted to the locked behavioral unit at a sister facility. -However, there was no documentation to indicate the reason for the expected discharge to the sister facility or the anticipated date of the pending discharge. The 7/5/24 nursing progress note documented Resident #76 had pushed another resident without cause. The charge nurse got in between the residents and separated them. Resident #76 continued to have behavioral outbursts. Resident #76 said she did not hit anyone, continued to use profanity and shouted at other residents. The resident was able to be redirected to the lobby but kept on showing aggression toward staff and other residents. The 7/11/24 change of condition note documented Resident #76 was sent to the hospital due to very hostile and aggressive behavior toward staff and was not able to be redirected. The physician ordered for the resident to be sent to the hospital for behavior management and then discharged to a sister facility. -A review of Resident #76's EMR did not reveal documentation to indicate that the resident or the resident's representative had been notified of the resident's immediate discharge to the hospital. C. Staff interviews The social services director (SSD) was interviewed on 10/15/24 at 12:46 p.m. The SSD said Resident #76 had been a resident at the facility, but had since been discharged to a sister facility. She said Resident #76 had a diagnosis of schizoaffective disorder and would refuse to take her psychotropic medications. She said the resident would constantly yell throughout the day, call emergency services daily and was verbally and physically aggressive. The SSD said the facility IDT had met with Resident #76's primary care physician (PCP) and determined, based on the resident's behaviors, the facility was not able to care for the resident and meet her needs. She said they planned to discharge the resident to a sister facility, however the paperwork was taking a long time. She said, in the meantime, the resident was sent to the hospital due to her behaviors and the hospital was instructed to discharge her to the accepting sister facility. The SSD said she was not aware if Resident #76 was given a 30-day or immediate discharge notice. She said Resident #76 was her own responsible party. She said she never discussed Resident #76's right to appeal the discharge with her or her family. The director of nursing (DON) and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:00 p.m. The DON said Resident #76 had severe mental health issues and would not take her medications, despite multiple attempts by multiple staff members. She said Resident #76 was disruptive to the community and verbally and physically aggressive. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the facility determined Resident #76's needs would be better met at a sister facility. The RCC said the facility did not issue Resident #76 a 30-day or immediate discharge notice when the resident was discharged to the hospital. The RCC said the facility did not provide Resident #76 with the education of the right to appeal the discharge. The RCC said a 30-day discharge notice should be given when the facility determined they could not meet a resident's needs. She said the discharge notice should include the resident's right to appeal the discharge. She said the discharge process should be documented in the resident's medical record and be included as part of the comprehensive care plan. The NHA was interviewed on 10/15/24 at 6:00 p.m. The NHA said the facility did not provide Resident #76 with a discharge notice. She said a 30-day discharge notice should have been provided and education given to the resident regarding the appeal process. The NHA said the facility felt they could not care for Resident #76 due to her unpredictable behavior.

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews the facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital for one (#76) of two residents reviewed for discharge out of 39 sample residents. Specifically, the facility failed to reassess Resident #76's status at the time the resident sought to return to the facility after a facility-initiated transfer to the hospital, and directed the hospital to discharge the resident to a sister facility instead of allowing the resident to return to the facility. Findings include: I. Facility policy and procedure The Facility-Initiated Transfer or Discharge policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by this facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice to pay for a stay at this facility; or the facility ceases to operate. Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. If the facility does not permit a resident's return to the facility based on an inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. The facility will send a copy of the discharge notice to a representative of the Office of the State Long Term Care Ombudsman. Notice will occur at the same time the notice of discharge is provided to the resident and resident representative. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility. II. Resident #76 A. Resident status Resident #76, age 65, was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), the diagnoses included schizoaffective disorder, bipolar disorder. The 7/8/24 minimum data set (MDS) assessment revealed the resident had short term memory impairment with severe impairment in making decisions regarding daily life. She required supervision or was independent with all activities of daily living (ADL). The assessment documented the resident had hallucinations, delusions, physical behaviors directed toward others, verbal behaviors directed toward others and wandering during the assessment period. The assessment indicated that the resident's return to the facility was not anticipated and active discharge planning had occurred. B. Record review The behavioral care plan, initiated on 7/5/24, documented Resident #76 was verbally aggressive with staff and peers. The resident had a history of calling emergency services if her expectations were not met, declining medication if they appeared different or a different brand from a previous facility, physically hitting another resident and making false accusations. Resident #76 was difficult to redirect when cycling. She yelled and expressed her delusions and hallucinations at herself in the mirror. The interventions included administering medications as ordered, anticipating and meeting needs promptly, documenting and recording behavioral episodes, encouraging the resident to verbalize feelings, establishing a rapport, maintaining a calm, slow and understandable approach, notifying the physician and responsible party of episodes of aggression and abusive behaviors, observing and documenting changes in behavior and potential triggers, observing for clinical factors influencing behavioral indicators, reducing stimuli, and staying calm and composed, avoiding direct eye contact and staring, using short and clear sentences and avoiding any chance for a power struggle. -A review of the comprehensive care plan did not reveal a discharge care plan had been developed. Cross reference F622: the facility failed to ensure a proper discharge process was provided to Resident #76. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/27/24 behavior progress note documented Resident #76 began speaking over other speakers during a resident meeting with a resident advocate. The facility staff attempted to address the resident's behavior by asking her to hold her comments until the appropriate time, however Resident #76 continued to speak over others, refused to listen and continued to disrupt the meeting. The 7/2/24 behavior progress note documented Resident #76 had provided a personal shopping list to the activity director (AD). Upon asking the resident some questions about the items, Resident #76 became verbally aggressive, repeatedly using profane language, despite the AD attempting de-escalation techniques. The 7/3/24 behavior progress note documented Resident #76 called the police stating that someone had stolen her money. The 7/5/24 interdisciplinary team (IDT) progress note documented Resident #76 continued to express delusions, disorganized thoughts and speech, chaotic behavior, anxiety, apathy and blank facial expressions. The 7/5/24 IDT note further indicated Resident #76 had been accepted to the locked behavioral unit at a sister facility. The 7/5/24 nursing progress note documented Resident #76 had pushed another resident without cause. The charge nurse got in between the residents and separated them. Resident #76 continued to have behavioral outbursts. Resident #76 said she did not hit anyone, continued to use profanity and shouted at other residents. The resident was able to be redirected to the lobby but kept on showing aggression toward staff and other residents. The 7/6/24 nursing progress note, documented at 6:37 a.m., revealed Resident #76 had an episode of yelling and screaming at staff and refused to take her evening medication on 7/5/24. She did not sleep and was wandering the hallways. The 7/6/24 nursing progress note further indicated that the resident was being sent to the hospital due to her behavior and that they had spoken with the hospital and informed them to transfer her to another facility at discharge. Another 7/6/24 nursing progress note documented the resident returned to the facility at 6:33 p.m. and had refused all care at the hospital. The 7/8/24 physician progress notes documented the resident had exhibited 27 reported behaviors since her admission to the facility, including dissatisfaction with meals, calling emergency services for non-emergencies, loud outbursts in the dining room, intrusive behaviors, delusions, hallucinations, disorganized thinking, persistent feelings of being watched or persecuted and strong beliefs that were not based in reality. The resident was scheduled to transfer to another facility from the hospital. The 7/8/24 behavior progress note documented Resident #76 displayed almost harmful behavior by standing close to a male resident and looking like she was going to push him out of her way. The NHA intervened and redirected Resident #76 into alternate activities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/11/24 change of condition note documented Resident #76 was sent to the hospital due to very hostile and aggressive behavior toward staff and she was not able to be redirected. The physician ordered for the resident to be sent to the hospital for behavior management and then discharged to a sister facility. -However, review of Resident #76's electronic medical record (EMR) revealed there was no documentation to indicate the facility had reassessed the resident after her transfer to the hospital to determine if the resident was able to return to the facility. -There was no documentation in Resident #76's EMR to indicate what needs the facility could not meet after the resident's hospitalization . III. Staff interviews The social services director (SSD) was interviewed on 10/15/24 at 12:46 p.m. The SSD said Resident #76 had been a resident at the facility, but had since been discharged to a sister facility. She said Resident #76 had a diagnosis of schizoaffective disorder and would refuse to take her psychotropic medications. She said the resident would constantly yell throughout the day, call emergency services daily and was verbally and physically aggressive. The SSD said the facility IDT had met with Resident #76's primary care physician (PCP) and determined, based on the resident's behaviors, the facility was not able to care for the resident and meet her needs (see 7/8/24 physician progress note above). -However the facility did not have any documentation indicating a discharge plan was in progress and had been discussed with the resident. The SSD said they planned to discharge the resident to a sister facility, however the paperwork was taking a long time. She said, in the meantime, the resident was sent to the hospital due to her behaviors and the facility instructed the hospital to discharge her to the accepting sister facility. The SSD said Resident #76 was her own responsible party. She said she never discussed the discharge planning with Resident #76. The SSD said she was responsible for discharge planning. She said a care plan focus for discharge planning should have been developed within Resident #76's comprehensive plan of care. The director of nursing (DON) and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:00 p.m. The DON said Resident #76 had severe mental health issues and would not take her medications, despite multiple attempts by multiple staff members. She said Resident #76 was disruptive to the community and verbally and physically aggressive. The DON said the facility determined Resident #76's needs would be better met at a sister facility. The RCC said the discharge process should be included as part of the comprehensive care plan. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 10/15/24 at 6:00 p.m. The NHA said the SSD was responsible for documenting the active discharge plan and developing the discharge plan of care. The NHA confirmed the active discharge process and the discharge care plan was not documented for Resident #76.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on record review and interviews, the facility failed to incorporate the recommendations from the PASRR (preadmission screening and resident review) Level II determination and evaluation report into the assessment, care planning and transition of care for two (#65 and #43) of three residents reviewed out of 39 sample residents. Specifically, the facility failed to initiate therapy as recommended by the PASRR Level II in a timely manner for Resident #65 and Resident #43. Findings include: I. Facility policy and procedure The Behavioral Health Services policy and procedure, revised February 2019, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress. II. Resident #65 A. Resident status Resident #65, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included schizophrenia (a chronic illness that effects a persons thoughts, feelings and behaviors), history of suicidal behavior and third degree burns over more than 60% of his body. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed set up assistance with eating, oral hygiene, toileting and personal hygiene. B. Record review Resident #65's care plan, revised 10/10/24, revealed the resident had a Level II PASRR focus of at risk for complications due to meeting the criteria for referral for evaluation and treatment. The goal was to avoid complications of the mental health diagnosis to the extent possible. Interventions included to allowing the resident to make choices within decision making abilities, allowing the resident time to adjust to changes in routine and schedule, providing a psychiatric/psychology evaluation as indicated/ordered, and referring the resident the resident was referred for psychiatric psychiatric case consultation, therapy and crisis intervention/safety plan. Resident #65's PASRR Level II, dated 9/13/24, documented the recommended treatment was to provide psychiatry case consultation, case management, individual therapy and a crisis intervention/individual safety plan. The 10/10/24 progress note documented a referral was sent per Resident #65's request for counseling. A review of the October 2024 CPO revealed a physician's order for a counseling referral was placed on 10/10/24. -However, the facility failed to process the referral until 10/10/24, three weeks after the Level II PASRR notice of determination was received. III. Resident #43 A. Resident status Resident #43, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2024 CPO, diagnoses included bipolar disorder (mental disorder that causes abnormal shifts in a person's mood and behavior), acute and chronic respiratory failure and muscle wasting. The 9/3/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She had no behaviors and did not reject care. The resident was dependent on staff with transfers, toilet use, personal hygiene and bathing. B. Record review Resident #43's care plan, revised 8/12/24, documented the resident had a level II PASRR for self isolation and a medical diagnosis that required adjunctive behavioral care. The interventions included a focus of staff to work with the resident to enhance her quality of life by implementing the PASRR Level II recommendations to prevent and mitigate effects of the major mental illness. The interventions included providing a psychiatry consultation and providing individual therapy. A behavioral health services referral was documented on 3/22/24 for Resident #43. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A therapy progress note was entered on 6/17/24. A review of the residents October 2024 CPO did not reveal a physician's order for behavioral health services. -A review of Resident #43's electronic medical record (EMR) did not reveal additional documentation that the resident was receiving behavioral services. IV. Staff interviews The social service director (SSD) was interviewed on 10/15/24 at 1:00 p.m. The SSD said it was her responsibility to facilitate referrals for behavioral health services. She said she had referred Resident #43 to behavioral health services, then referred the resident to another behavioral health services provider and when that provider vacated the position. The SSD said she did not have documentation indicating she initiated a new referral for Resident #43 upon the behavioral health services provider leaving their position at the facility. The SSD said she needed help and was not able to keep up with all of her responsibilities and did not have an assistant to help her. The SSD said a referral for behavioral health services for Resident #65 was sent on 10/10/24 and the notice of determination was obtained on 9/19/24. She said a week was a reasonable amount of time to expect a referral to be sent. -However, Resident #65's notice of determination was received on 9/19/24 and a referral to behavioral health services was not completed until 10/10/24 (during the survey). The director of nursing (DON) was interviewed on 10/15/24 at 5:01 p.m. The DON said she was not aware that behavioral health services were not being provided for Resident #43 or Resident #65. She said the SSD needed help to ensure the residents receive the care they need.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on observations, record review and interviews, the facility failed to ensure services provided to residents met professional standards of quality for one (#15) of one resident out of 39 sample residents. Specifically, the facility failed to ensure Resident #15's as needed (PRN) pain medications had physician ordered parameters related to the strength of the medications and the severity of the resident's pain level (on a pain scale of 1-10). Findings include: I. Professional Reference According to the Society for Post Acute and Long-term Care (AMDA), Pain Management clinical practice guideline (2021) , retrieved on 10/17/24 from: https://paltmed.org/sites/default/files/2024-02/PainManagement2021CPGFinal.pdf, Levels of pain management identify pain levels by severity. Non-opioid analgesics for mild pain, low potency opioids for moderate pain, high potency opioids for severe pain, and adjunctions combined with any step. Giving PRN analgesics based on guesswork may limit the benefits and increase the risk of harm. Orders for PRN analgesics need to be clear and specific about the location and type of pain that they are intended to treat. II. Facility policy and procedure The Administering Medications policy and procedure, dated April 2019, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:00 p.m. It revealed in pertinent part, If a resident uses PRN medications frequently, the attending physician and interdisciplinary care team,with support from the consultant pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. III. Resident Status Resident #15, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included schizoaffective disorder, bipolar disorder and diabetes mellitus. The 7/19/24 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. IV. Record Review Review of Resident #15's October 2024 CPO revealed the following physician's orders: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone oral tablet 5 milligrams (mg). Give 5 mg by mouth every six hours as needed for pain,ordered 9/29/24. -There were no administration parameters for the level of pain the medication should be given for. Tramadol oral tablet 50 mg. Give 50 mg by mouth every six hours as needed for pain, ordered 9/28/24. -There were no administration parameters for the level of pain the medication should be given for. Tylenol (acetaminophen) oral tablet 325 mg. Give two tablets by mouth every six hours as needed for fever/chills or mild pain. -The order indicated the Tylenol should be given for mild pain, however, there was no indication as to what mild pain was on a scale of 1-10. Resident #15's pain management care plan, initiated 1/5/24, revealed the resident was at risk for pain or discomfort due to general decline. The goal was for the resident's pain to be relieved to a tolerable level as indicated by the resident, using verbal or nonverbal communication to the extent possible. Interventions included assessing the resident for non-verbal indicators of pain and assessing the resident's pain every shift as indicated. V. Staff Interviews Licensed practical nurse (LPN) # 1 was interviewed on 10/15/24 at 11:36 a.m. LPN #1 said PRN pain medications should have pain perimeters. LPN #1 said a resident was asked to verify their pain level on a pain scale of 1-10 and to describe where the pain was. LPN #1 said the physician's orders were reviewed for the pain perimeters for which strength of medication to give. LPN #1 said if a resident was non-verbal she would use a non-verbal pain scale. LPN #1 said she assessed facial expressions and body tension to determine a pain scale level and then medicated the resident for pain based on the severity of pain and medication order. LPN #3 was interviewed on 10/15/24 at 11:38 a.m. LPN #3 said some pain medications were scheduled and some were PRN. LPN #3 said the physician's orders should have pain scale parameters. LPN #3 said each medication should specify what level of pain, on a 1-10 pain scale, the medication should be given for. LPN # 3 said if a resident requested a specific medication she would verify if their reported pain level met the ordered pain level parameter. LPN #3 reviewed the PRN pain medication orders for Resident #15. LPN #3 said she thought there should be pain scale parameters for each medication, but she said she would verify it with the director of nursing (DON). LPN #3 said the PRN pain medication orders for Resident #15 were ordered by an emergency department physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:02 p.m. The DON said pain medications should have administration parameters to indicate what level of pain each medication should be given for. The RCC said the facility had reviewed, updated and audited the PRN pain medication orders for Resident #15 (during the survey).

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on record review and interviews, the facility failed to provide the resident representative with the proper discharge notifications for one (#182) of two residents out of 39 sample residents. Specifically, the facility failed to develop and implement a collaborate discharge plan with Resident #182 Findings include: I. Facility policy and procedure The Facility-Initiated Transfer or Discharge policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. II. Resident #182 A. Resident status Resident #182, age 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included dementia, type 2 diabetes mellitus, depression and history of traumatic brain injury. The 9/26/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. He required setup assistance with dressing and eating and supervision with personal hygiene and toileting. The resident had hallucinations and physical and verbal behavioral symptoms directed towards others. -The assessment indicated active discharge planning was not occurring for the resident. -The assessment indicated no referral had been made to the local contact agency and the reason was referral not wanted. B. Record review A behavior note, documented on 10/3/24 at 7:52 p.m., revealed referrals were sent to many memory care facilities for placement and the facility would keep Resident #182 safe until he could be transferred to a more appropriate facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note, documented on 10/8/24 at 3:48 p.m., revealed the resident entered a female resident's room without permission the prior evening and kissed her. The facility was actively seeking placement at other facilities for appropriate placement of Resident #182 and the referral process was prioritized to maintain the safety and security of the community. A behavior note, documented on 10/11/24 at 4:12 a.m., revealed the resident was exhibiting behaviors of fear, agitation, anger, anxious, restless, and combativeness. The resident was hallucinating and hit and kicked multiple staff members. The facility called 911 to assist staff and the resident was transported to the hospital for evaluation. -There was no documentation in Resident #182's EMR to indicate the resident or resident representative had been involved in the development of a discharge plan for the resident. C. Staff interviews The social services director (SSD) was interviewed on 10/15/24 at 12:49 p.m. The SSD said Resident #182's discharge planning process was not documented in the resident's EMR or the resident's comprehensive care plan. The regional clinical consultant (RCC) was interviewed on 10/15/24 at 5:00 p.m. The RCC said the discharge process should be documented in the resident's medical record and be included as part of the comprehensive care plan. The NHA was interviewed on 10/15/24 at 6:00 p.m. The NHA said the SSD was responsible for documenting the active discharge plan and developing the discharge plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for one (#24) of four residents reviewed for assistance with ADLs out of 39 sample residents. Specifically, the facility failed to ensure Resident #24's fingernails were trimmed and clean. Findings include: I. Facility policy The Activities of Daily Living (ADL), Supporting policy, revised March 2018, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:30 p.m. It read in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Residents will be provided with care, treatment and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care). A resident's ability to perform ADLs will be measured using clinical tools, including the MDS (minimum data set) assessment, functional decline or improvement will be evaluated in reference to the assessment reference date (ARD). Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated and revised as appropriate. II. Resident #24 A. Resident status Resident #24, age 85, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease and chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/30/23 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. He required setup or clean up assistance with eating and oral hygiene. He required substantial/maximal assistance with toileting hygiene, showering/bathing himself and upper and lower body dressing. B. Observations and resident interview On 10/10/24 at 4:03 p.m. Resident #24's finger nails were long and dirty. His fingernails extended past the tip of his fingers and had brown matter underneath them. Resident #24 said he wanted his fingernails cut. He said he did not know the last time his fingernails were trimmed. C. Record review The ADL care plan, revised on 3/10/23, documented Resident #24 had an ADL self-care performance deficit related to cellulitis, deep vein thrombosis (DVT), anaphylaxis episode and history of venous ulcers. The resident preferred a sponge bath as an alternative when he did not want a shower. Interventions included bathing/showering, checking nail length and trimming and cleaning on bath days and as necessary, reporting any changes to the nurse, offering a sponge bath two to three times a week and providing a sponge bath when a full bath or shower could not be tolerated. D. Staff interviews Licensed practical nurse (LPN) #6 was interviewed on 10/10/24 at 4:05 p.m. LPN #6 said Resident #24's fingernails were long and dirty. She said staff should be washing residents' hands all the time. She said residents' fingernails should be trimmed every couple of weeks. She said if the resident's nails were not trimmed, the residents could hurt themselves. She said staff should be keeping the residents' nails clean and trimmed. The director of nursing (DON) was interviewed on 10/15/24 at 5:00 p.m. The DON said nail care should be done as needed and should be checked during bathing. She said CNAs should be cleaning residents' hands and checking their nails. She said the nurses would do the trimming of fingernails when necessary. The DON said staff should be cleaning residents' hands multiple times per day to keep their hands and nails clean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to ensure residents were provided services that meet professional standards for one (#51) of one resident out of 39 sample residents. Specifically, the facility failed to ensure Resident #51's leg wraps for lymphedema (a chronic condition that causes swelling due to a buildup of lymph fluid in the body) were ordered in a timely manner. Findings include: I. Resident status Resident #51, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included lymphedema, heart disease, and obesity. The 9/24/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She was dependent on staff for dressing and personal hygiene. II. Record review A progress note documented by the nurse practitioner (NP), dated 9/17/24 at 11:15 a.m., revealed Resident #51 was referred to the lymphedema clinic and the NP requested the facility obtain lymphedema wraps for the resident. -However, a physician's order for the lymphedema wraps was not entered into Resident #51's electronic medical record (EMR), which resulted in the resident not receiving the recommended treatment. The care plan for risk of skin breakdown was revised on 8/28/23. An intervention was to administer treatments as ordered. There was not a care plan for edema (swelling) or use of the wraps. III. Staff interviews The director of nursing (DON) was interviewed on 10/14/24 at 1:00 p.m. The DON said they had problems finding someone to come to the facility to measure Resident #51's legs for the lymphedema wraps. She said measuring the legs was a specialized service and there were specific companies designated to do so. The regional clinical consultant (RCC) sent an email on 10/14/24 at 1:48 p.m. which indicated the DON had entered a physician's order into Resident #51's EMR for the leg wraps and documented a progress note. The RCC said the facility was working with the director of rehabilitation to get the needed measurements.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain vision abilities for one (#18) of one resident out of 39 sample residents. Specifically, the facility failed to arrange optometry services timely for Resident #18. Findings include: I. Resident #18 A. Resident status Resident #18, age 67, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body). The 9/16/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of nine out of 15. He required partial/moderate assistance for upper body dressing and personal hygiene. He required supervision or touching assistance with oral hygiene. The assessment indicated the resident had adequate vision and had corrective lenses. B. Resident observation and interview On 10/9/24 at 3:41 p.m. Resident #18 said he had asked to be seen by the eye doctor and had not been seen. He said he needed glasses to see. During the interview, Resident #18 was not wearing eyeglasses. C. Record review A 9/19/24 admission summary note documented Resident #18 indicated that he would like a dental and vision referral. The activities care plan, initiated on 9/23/24, documented Resident #18's activities of interest included driving, cooking barbeque, camping, hiking, watching preferred television choices, going outdoors, socializing with peers and listening to music such as R&B and oldies. Interventions included staff making sure the resident had his glasses on during group activities of interest due to a visual deficit. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ancillary care plan, initiated 10/14/24, documented Resident #18 would have access to audiology, dental, podiatry and ophthalmology services quarterly per request and/or as needed. Interventions included ensuring eye health and visual acuity, performing regular eye exams to detect vision changes and eye conditions, as tolerated prescribing and managing eyeglasses or contact lenses, if needed treating common eye conditions (cataracts, glaucoma) and educating Resident #18 on eye care and safety measures. -There was no documentation in Resident #18's electronic medical record (EMR) to indicate the resident had been referred to see the eye doctor. -A consent for vision services was not obtained until 10/4/24. D. Staff interviews The social services director (SSD) was interviewed on 10/15/24 at 12:46 p.m. The SSD said when she started working at the facility in October of 2023, none of the residents had been reviewed or referred for ancillary services. She said most of the new admissions were caught up, however, she said recently she had struggled with referring residents for ancillary services, such as vision services timely. She said she was doing the best she could but it had been hard for her to keep up. The SSD said ancillary services were offered every quarter and upon admission. She said she went over ancillary services during care conferences or in conversation. She said she would ask the residents if they needed vision, hearing or dental services. The SSD said the eye doctor came to the facility quarterly. She said the eye doctor would be at the facility on 10/22/24 and she would make sure Resident #18 was seen. The director of nursing (DON) was interviewed on 10/15/24 at 5:00 p.m. The DON said ancillary services, including vision services should be offered to all residents. She said she did not know how often residents were referred for ancillary services. She said residents needing to be seen by the eye doctor should be seen every six months. The DON said social services was responsible for scheduling ancillary appointments, along with the interdisciplinary team (IDT) involvement. She said ancillary services should be arranged and scheduled timely. The DON said Resident #18 should have been seen by the eye doctor more timely. The nursing home administrator (NHA) was interviewed on 10/15/24 at 6:00 p.m. The NHA said social services was responsible for scheduling ancillary services. She said she recognized the SSD needed help to be able to submit referrals and complete her job duties timely. She said ancillary services should be submitted timely.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to ensure three (#43, #51 and #66) of three residents with limited mobility reviewed for range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion out of 39 sample residents. Specifically, the facility failed to establish a consistent restorative nursing program within the facility to ensure Resident #43, Resident #51 and Resident #66 did not have a potential decline in activities of daily living (ADL). Findings include: I. Facility policy The Restorative Nursing Services policy, revised July 2017, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, Restorative nursing care consists of nursing intervention that may or may not be accompanied by formalized rehabilitative services (physical, occupational or speech therapies). Restorative goals and objectives are individualized, resident-centered, and are outlined in the resident's plan of care. 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 #43 A. Resident status Resident #43, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2024 computerized physicians orders (CPO), diagnoses included muscle weakness, chronic kidney disease, bipolar disorder, acute and chronic respiratory failure and muscle wasting. The 9/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff with transfers, toilet use, personal hygiene and bathing. The assessment indicated the resident had no behaviors and did not reject care. (continued on next page)

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Amberwood Post Acute	4686 E Asbury Cir Denver, CO 80222

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS assessment, the resident did not receive restorative nursing services and the last time the resident received physical therapy services was on 8/28/24 for a total of 31 minutes. B. Record review A review of a list of residents on restorative programs documented Resident #43 was on a restorative program. A review of the restorative nurse aides (RNA) range of motion task charting from 9/11/24 to 10/11/24, a period of 30 days, revealed documentation that Resident #43 refused restorative services on 9/16/24. -There was no other documentation of the resident having received restorative services. -A review of Resident #43's October 2024 CPO did not reveal any physician's orders for restorative services. -A review of the resident's comprehensive care plan did not reveal a care plan focus for restorative services. III. Resident #51 A. Resident status Resident #51, age greater than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included lymphedema, heart disease and obesity. The 9/24/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for dressing and personal hygiene. B. Resident interview Resident #51 was interviewed on 10/9/24 at 9:19 a.m. Resident #51 said her restorative program was not done as often as it was supposed to be. She said the facility had cut back on the restorative services program. Resident #51 said she was supposed to have restorative services two to three times per week but that had not happened. She said she needed restorative services because her knees were bone on bone and she needed to do what she could to maintain her abilities. C. Record review A review of a list of residents on restorative programs documented Resident #51 was on a restorative program. A review of the RNA restorative range of motion task charting revealed Resident #51 had two restorative sessions from 9/11/24 to 10/11/24, a period of 30 days. -A review of Resident #51's October 2024 CPO did not reveal any physician's orders for restorative services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the residents comprehensive care plan did not reveal a care plan focus for restorative services. IV. Additional record review A performance improvement plan (PIP) was provided by the director of nursing (DON) on 10/14/24 at 1:00 p. m. The PIP was dated 8/20/24 and read in pertinent part, It was identified that the facility failed to ensure that the documentation by the MDS nurse, RNAs and the DON was not completed accurately and there are many residents that have incomplete assessments and chart notes. The DON did not complete the attestations and the MDS nurse or the DON did not consistently enter notes in the chart of residents receiving restorative services. The RNAs did chart but the charting lacks substance and is not concise. A restorative team of the DON, the MDS nurse, RNA and the DOR (director of rehabilitation) was formed to evaluate the charting process and implemented a training meeting to ensure that the documentation is concise and completed promptly. The RNAs will complete the comments section of the RNA weekly summary with a note about the resident's response to the restorative treatment they received. The MDS nurse and the DON will complete restorative notes going forward and will discuss outstanding documentation weekly. The DON will complete the attestations monthly. The RNAs will complete 6 (six) days of restorative with 2 (two) programs consisting of 15 minutes each to capture on the MDS assessment. Audit in 4 (four) weeks to evaluate the effectiveness of the new charting process - the expectation is that a 25% (percent) improvement in restorative charting will be achieved within the first month and charting will improve to reflect 100% compliance within the next 60 days. -However, record review for Resident #43 and Resident #51 revealed there was no documentation to indicate the residents were receiving their restorative programs (see record review above). V. Staff interviews The DON was interviewed on 10/14/24 at 1:00 p.m. The DON said the facility had a PIP in place for the restorative program. She said the facility went some time without a restorative program and realized they needed to train staff. She said the restorative program was back in full effect. -However, record review for Resident #43 and Resident #51 revealed there was no documentation to indicate the residents were receiving their restorative programs (see record review above). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The NHA provided a clarification email on 10/14/24 at 1:25 p.m. The NHA's email said the facility had had daily coverage for the restorative program for the past year and a half and the only time restorative staff were pulled from the program was when a scheduled certified nurse aide (CNA) called out sick or went on break. The restorative program supervisor (RNAS) was interviewed on 10/15/24 at 3:58 p.m. The RNAS said when a resident was placed on a restorative program, she was responsible for adding the task for charting so the RNA was reminded to chart the restorative service. She said the restorative programs needed work and that was why the PIP was started in September 2024. The RNAS said she began looking at the restorative program during other training and realized the facility needed to be more compliant with the restorative services. She said it was the responsibility of the therapy department to train restorative staff on how to perform the restorative programs. The RNAS reviewed the electronic medical records (EMR) for Resident #43 and Resident #51 and said she was not able to find documentation that restorative services were provided to either resident. She said if restorative services were not provided to the residents they would be at risk of decline in their functional abilities. The DON was interviewed a second time on 10/15/24 at 5:14 p.m. The DON said she began helping with the restorative program at the end of August 2024 when she found the restorative RNAs did not have access to the facility's electronic charting system in order to document the restorative services. She said a recent audit of resident restorative programs (during the survey) confirmed the RNAs were still not documenting appropriately. 48114 VI. Resident #66 A. Resident status Resident #66, under the age 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included anoxic brain damage (lack of oxygen to the brain) and persistent vegetative state. The 11/13/23 MDS assessment revealed the resident had severe cognitive impairment and a BIMS assessment was unable to be conducted. He required total staff assistance with oral hygiene, toileting hygiene, showering/bathing himself, upper and lower body dressing, personal hygiene and rolling left and right. B. Record review The activities of daily living (ADL) self-care deficit care plan, revised on 11/3/23, documented Resident #66 had actual ADL/mobility decline and required assistance related to vegetative state. Interventions included providing the assistance of one to two people for ADLs. The 9/19/24 rehabilitation screening form documented Resident #66 would benefit from occupational therapy (OT) to assess for a restorative nursing program (RNP) to follow through with upper extremity (UE) range of motion (ROM) and splinting. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident #66's EMR revealed there was no documentation regarding restorative services being provided for Resident #66. C. Staff interviews The MDS coordinator (MDSC) was interviewed on 10/15/24 at 3:58 p.m. MDSC said Resident #66 had been on a restorative program and then had been back and forth to the hospital several times. She said Resident #66 should have been restarted on restorative services for passive range of motion for his wrist and joints. The MDSC said it was important for Resident #66 to receive restorative services so he did not get contractures. She said therapy would be evaluating the resident tomorrow (10/16/24) and recommending a new restorative program for him. The DON was interviewed on 10/15/24 at 5:00 p.m. The DON said she was not aware that she had to re-initiate the restorative program when Resident #66 returned from the hospital. She said she was not made aware that the resident was not receiving the passive range of motion services. She said Resident #66 would be evaluated again by therapy and put on a restorative program tomorrow (10/16/24). The NHA was interviewed on 10/15/24 at 6 p.m. The NHA said she thought the restorative issues had been corrected. She said she would be meeting with the RNAs weekly to look at restorative documentation going forward.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on interviews and record review, the facility failed to ensure one (#65) of two residents reviewed for accidents out of 39 sample residents received adequate supervision to decrease and/or prevent risk for accident hazards. Specifically, the facility failed to implement a plan of care that adequately addressed the risks posed to Resident #65 and other residents in the facility due to Resident #65's smoking habit and history of self-inflicted injury from fire. Findings include: I. Facility policy and procedure The Smoking policy, dated 6/17/24, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, Smoking is a privilege. To be an independent smoker, residents must demonstrate that they are safe to smoke by staff assessment and must comply with all smoking rules. II. Resident #65 A. Resident status Resident #65, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included schizophrenia (a chronic illness that effects a persons thoughts, feelings and behaviors), history of suicidal behavior and third degree burns over more than 60% of his body. The 9/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed set up assistance with eating, oral hygiene, toileting and personal hygiene. B. Record review The admission assessment was completed on 9/19/24 by licensed practical nurse (LPN) #7. It documented the resident did not smoke and did not use tobacco products. A smoking assessment was completed on 9/25/24 at 5:08 p.m. by registered nurse (RN) #1. The assessment revealed Resident #65 smoked, smoked over ten times per day, was able to light his own cigarettes and was able to smoke without supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The trauma care plan, initiated on 10/10/24, revealed Resident #65 was at risk for decreased psychosocial well being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to being in a self inflicted fire or explosion and triggered by conversations about this event when not prompted or initiated by self. The resident's goal was to demonstrate effective coping strategies. The interventions included monitoring Resident #65 for signs and symptoms of decreased psychosocial wellbeing, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and reporting abnormal findings to the physician, and avoid triggering the resident by not engaging or initiating questions regarding the self inflicted fire that resulted in his burns. The psychosocial care plan, initiated 10/10/24, identified the resident had a history of hallucinations, suicidal ideations and delusions which were controlled by medications. The goals were to have the residents' psychosocial needs met and minimize the risk for decline in mood and behavior. The interventions included allowing the resident to voice his feelings and frustrations as indicated and to observe for tearfulness, increased agitation and decreased participation in care. -A review of Resident #65's comprehensive care plan did not reveal a care plan that addressed the resident's smoking. -A review of Resident #65's electronic medical record (EMR) did not include documentation to indicate the facility's plan to monitor Resident #65 who had a history of self-inflicted burns, smoked independently and had possession of a lighter III. Staff interviews The social service director (SSD) was interviewed on 10/15/24 at 12:29 p.m. The SSD said Resident #65 obtained the burns on his body by dousing himself in gasoline at a gas station and then lighting himself on fire two years ago prior to his admission to the facility. She said he was hallucinating and hearing voices when that incident occurred and was subsequently diagnosed with schizophrenia and put on medication. She said the facility only had one supervised smoker (this was not Resident #65). She said she was not aware that Resident #65 was not supervised during smoking. The SSD said there should have been a safety plan in place and a care plan to address Resident #65's safety when smoking. She said Resident #65 should be supervised when smoking due to his history of self inflicted burns. RN #2 was interviewed on 10/15/24 at 1:21 p.m. RN #2 said she was aware of how Resident #65 obtained the burns on his body and she was not aware he was smoked. She said RN #1 usually was responsible for completing the smoking assessments for residents. RN #2 said upon reflection she did remember seeing cigarettes and a lighter on the resident's dresser in his room recently. The assistant director of nursing (ADON) was interviewed on 10/15/24 at 1:24 p.m. The ADON said she was aware of how Resident #65 obtained the burns on his body. She said he was not safe to smoke unsupervised. The NHA and the director of nursing (DON) were interviewed together on 10/15/24 at 1:49 p.m. The DON said Resident #65 denied smoking upon admission. She said the resident did not exhibit concerns of fire safety upon admission. She said she was not aware the resident currently smoked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said Resident #65 was able to smoke independently. She said he deserved the autonomy to be able to smoke until he showed otherwise. IV. Facility follow-up The NHA provided documentation on 10/15/24 at 6:00 p.m. that showed Resident #65 would be evaluated daily to continue to smoke independently for the next 90 days to ensure the safety of Resident #65 and the residents in the community.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51160 Based on observations, record review and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater. Specifically, the medication administration observation error rate was 14.63%, or six errors out of 41 opportunities for error. Findings include: I. Facility policy and procedure The Administering Medications policy and procedure, dated April 2019, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:00 p.m. It revealed in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI (quality assurance and performance improvement) committee to inform process changes and or the need for additional staff training. II. Medication administration observations On 10/10/24 at 9:02 a.m. licensed practical nurse (LPN) #2 was preparing and administering medications for Resident #3. The resident had a physician's order for Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml (milliliter). Inject 50 units subcutaneously in the morning for diabetes mellitus, ordered 8/23/24. -LPN #2 entered the room of Resident #3 with the resident's Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml. She turned the dial on the insulin pen to read 50 units, cleaned the resident's abdominal injection site with a personal hygiene wipe and administered the insulin injection to the resident without priming the insulin pen. Cross reference F760 for failure to ensure residents were free from significant medication errors. On 10/10/24 at 9:28 a.m. LPN #2 was preparing and administering medications for Resident #49. The resident had physician's orders for the following medications: Amlodipine Besylate oral tablet 10 mg (milligram), give one tablet by mouth one time a day for hypertension (HTN), hold for a systolic blood pressure (maximum blood pressure in your arteries when your heart beats) less than 110 mm/Hg (millimeters of mercury), ordered 7/27/2024. -LPN #2 did not check Resident #49's blood pressure prior to administration. Senna-Docusate Sodium oral tablet 8.6-50 mg, give 8.6 mg orally one time a day for bowel management, ordered 7/27/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN #2 administered two tablets of senna-docusate, not one tablet as indicated in the physician order. On 10/15/24 at 9:04 a.m. LPN #5 was preparing and administering medications for Resident #43. The resident had physician's orders for the following medications: Psyllium oral packet (Metamucil) 25%, give one packet by mouth in the morning for constipation, ordered 8/28/2024. -The bulk bottle packaging directions read one rounded tablespoon, three times daily, however LPN #5 measured out three rounded plastic spoonfuls into one seven oz (ounce) glass. Aspirin oral capsule 81 mg, give one tablet by mouth one time a day, for cerebellar stroke syndrome, ordered 8/28/2024. -LPN #5 administered an 81 mg chewable aspirin tablet. Milk of Magnesia oral suspension, give 30 ml by mouth every 24 hours as needed for constipation, ordered 8/27/2024. -Resident #43 was administered the previous dose on 10/14/24 at 9:22 p.m., twelve hours prior. III. Staff interviews LPN #5 was interviewed on 10/15/24 at 9:37 a.m. LPN #5 said she used three spoonfuls of Metamucil because the package read one rounded tablespoon three times. The director of nursing (DON) and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:02 p.m. The DON said an insulin pen should be primed prior to administering the insulin. She said the pen should be dialed to two units and the insulin expelled from the pen prior to drawing up the prescribed dose of insulin. The DON said it was important to prime the insulin pen prior to administration to ensure the resident received the full dose of insulin. The DON said it was important to follow the physician's order when administering medications. The DON said if a resident received a higher amount of a medication, such as with the Metamucil, it could cause harm. The RCC said physician's orders for bulk medications, such as Metamucil, should match the directions on the bulk medication bottle. She said she would review and edit the physician's orders for Metamucil to make them more clear. She said the physician's order should match the format the facility was using, for example bulk versus a packet.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on observations and interviews, the facility failed to ensure one (#3) of one resident out of 39 sample residents were free of significant medication errors. Specifically, the facility failed to ensure the insulin pen was primed prior to administration for Resident #3. Findings include: I. Professional reference According to the Tresiba product information, dated July 2022, retrieved on 10/16/24 from https://www.mynovoinsulin.com/insulin-products/tresiba/support-and-resources/videos-and-resources.html, Priming the pen, turn the dose selector to 2 (two) units, hold the pen with the needle pointing up, tap the pen gently to allow any air bubbles to ride to the top, depress and hold the dose button with the needle pointing up. II. Facility policy and procedure The Administering Medications policy and procedure dated, April 2019, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:00 p.m. It revealed in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI (quality assurance and performance improvement) committee to inform process changes and or the need for additional staff training. Insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident. III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus. The 8/30/24 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. Observation (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 9:02 a.m. licensed practical nurse (LPN) #2 was preparing and administering medications for Resident #3. LPN #2 entered the room of Resident #3 with the resident's Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml. LPN #2 turned the dial on the insulin pen to read 50 units, cleaned the injection site on the resident's abdomen and administered the insulin to the resident. -LPN #2 did not prime the insulin pen prior to administering the insulin to the resident. C. Record review The October 2024 CPO documented the following physician's order: -Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml (milliliter). Inject 50 units subcutaneously in the morning for diabetes mellitus, ordered 8/23/24. IV. Staff interviews LPN #2 was interviewed on 10/10/24 at 9:28 a.m. LPN #2 said when she administered insulin, she would turn the dial on the insulin pen to the ordered unit dose. LPN #2 said she would clean the skin with an alcohol prep pad then injects insulin being sure to rotate injection sites. The director of nursing (DON) and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:02 p.m. The DON said an insulin pen should be primed prior to administration. She said the insulin pen should be dialed to two units and the insulin expelled from the pen prior to drawing up the prescribed dose of insulin The DON said it was important to prime the insulin pen to ensure the resident had received the full dose of insulin.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Post Acute	4686 E Asbury Cir Denver, CO 80222

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47960 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored in accordance with accepted professional standards for two of three treatment carts and one of three medication carts. Specifically, the facility failed to: -Ensure treatment carts were locked when unattended; and, -Ensure medication carts were locked when unattended. Findings include: I. Facility policy -The medication storage policy was requested from the facility but was not provided by the end of the survey on 10/15/24. II. Observations On 10/9/24 at 8:17 a.m. the treatment cart on the south hall was unlocked and unattended. Several residents and staff were walking in the hallway past the treatment cart. There were linens piled on top of the treatment cart. At 8:23 a.m. the treatment cart on the north hall was unlocked and unattended. There were several residents in the hall near the cart. At 2:14 p.m. the treatment cart on the south hall was unlocked and unattended. Residents were walking in the hallway, staff walked past the cart and maintenance walked past the cart. The cart remained unlocked until 2:33 p.m. when the nurse was notified and locked the cart. On 10/10/24 at 8:37 a.m. the treatment cart on the north hall was unlocked and unattended. A resident in a wheelchair went past the cart. At 8:39 a.m. the treatment cart on the south hall was unlocked and unattended. There were several residents walking by the cart in the hall. At 9:12 a.m. the treatment cart on the north hall was still unlocked and unattended. The nurse was notified and the cart was locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:41 p.m. the medication cart on the south hall was unlocked and unattended. A resident in a wheelchair went past the cart. Several staff members, including the director of nursing (DON), a therapy assistant and a certified nurse aide (CNA) passed the cart and the DON walked past the cart a second time. None of the staff members observed that the medication cart was unlocked. The nurse returned to the cart from a resident's room over 15 feet away from the cart at 1:46 p.m. and locked the cart at 1:51 p.m. III. Staff interviews An unidentified agency nurse was interviewed on 10/9/24 at 8:24 a.m. The agency nurse said the treatment cart should be locked when it was unattended so residents did not get into it. She said she had just arrived at the facility and the night shift staff must have left it unlocked. The DON was interviewed on 10/15/24 at 5:01 p.m. The DON said the treatment carts and medication carts should be locked when unattended. She said the carts had scissors and medications in them that would be dangerous to residents with mental health issues and wandering behaviors.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to assist residents in obtaining routine or emergency dental services as needed for three (#18, #32 and #51) of four residents reviewed for dental services out of 39 sample residents. Specifically, the facility failed to ensure dental services were offered to Resident #18, Resident #32 and Resident #51. Findings include: I. Facility policy The Emergency Dental Care policy, revised April 2007, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:30 p.m. It read in pertinent part, Emergency dental care is available to all residents of this facility. Emergency dental care is available on a twenty-four (24) hour basis. Should a resident need emergency dental care, the dental consultant shall be notified so that arrangements for the emergency care can be made. Social services shall contact the consultant dentist to set up the appointment. Should social services be unavailable, the charge nurse shall contact the consultant dentist. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate, broken, or otherwise damaged teeth or any problem of the oral cavity appropriately treated by a dentist that requires immediate attention. II. Resident #18 A. Resident status Resident #18, age 67, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body). The 9/16/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of nine out of 15. He required partial/moderate assistance for upper body dressing and personal hygiene. He required supervision or touching assistance with oral hygiene. The MDS assessment indicated the resident had no dental issues and was edentulous (did not have teeth). B. Resident interview and observation (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 was interviewed on 10/9/24 at 3:42 p.m. Resident #18 said he had asked to be seen by the dentist and had not seen the dentist since he was admitted to the facility. He said he would like to see the dentist and get dentures. He said he would like to eat hard food, such as steak. An observation of Resident #18's mouth during the interview revealed the resident had no teeth. C. Record review The care plan for nutrition, revised 9/16/24, documented Resident #18 had potential risk for altered nutritional intake related to being edentulous, left hemiplegia (paralysis of one side of the body), denied chewing difficulty and fed himself after some set-up assistance. Interventions included evaluating the need for assistance with eating and drinking as needed providing meal set-up assistance if needed, providing food preferences per resident choice and observing for signs and symptoms of dysphagia (swallowing difficulties) as evidenced by pocketing food in the mouth, coughing, choking, drooling or holding foods in mouth. The 9/19/24 admission summary note documented Resident #18,would like a dental and vision referral. The ancillary care plan, initiated 10/14/24, documented Resident #18 would have access to audiology, dental, podiatry and ophthalmology services quarterly, per request, and/or as needed. Interventions included ensuring oral health and preventing dental issues, scheduling regular dental check-ups and cleanings, providing treatment for dental conditions (fillings, extractions) as needed, educating Resident #18 and staff on oral hygiene practices and monitoring denture care and adjustments, if needed. -Review of Resident #18's electronic medical record (EMR) revealed there was no documentation indicating that a referral had been made for the resident to be seen by the dentist. -A consent for dental services was signed on 10/4/24, however, there was no documentation that the resident was referred to be seen by the facility's dental provider since his admission III. Resident #32 A. Resident status Resident #32, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2024 CPO, diagnoses included anxiety disorder and depression. The 8/12/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required setup or clean-up assistance with eating and oral hygiene. The MDS assessment indicated the resident had no dental issues and was edentulous. -However, the resident had upper and lower teeth which were chipped (see resident observation and interview below). B. Resident interview and observation (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #32 was interviewed on 10/9/24 at 2:20 p.m. Resident #32 said he had been asking to see the dentist since he was admitted to the facility. He said he had never been seen by the dentist. He said his teeth were bothering him and had some pain in his mouth. He said he had let staff know that he needed to be seen by the dentist and had not heard when he would be seen. An observation of Resident #32's mouth during the interview revealed the resident had upper and lower teeth that were chipped and needed to be repaired. C. Record review A 3/27/24 nurse practitioner note documented Resident #32 presented with a chief complaint of tooth pain, which had been managed with ibuprofen. The resident was seeking further relief from his symptoms and required a dental appointment. On 4/26/24 the social services note documented Resident #32 informed the social services director (SSD) of cracked teeth and tooth pain. The note indicated the SSD would submit an emergency evaluation to the dentist for the resident to be evaluated and treated by a dentist. On 6/6/24 the dental note documented Resident #32 was on the facility dentist's schedule for dental treatment, however, Resident #32 was in the hospital. The ancillary care plan, revised 8/7/24, documented Resident #32 would have access to audiology, dental, and ophthalmology services quarterly, per the resident's request, and/or as needed. Interventions included ensuring oral health and preventing dental issues, scheduling regular dental check-ups and cleanings, providing treatment for dental conditions (fillings, extractions) as needed, educating Resident #32 and staff on oral hygiene practices and monitoring denture care and adjustments. On 9/5/24 a progress note documented Resident #32 was not seen by the dentist and he was placed on the reserve list for the next dental visit. On 9/5/24 the dental note documented Resident #32 was on the schedule to be seen for treatment, but the dentist ran out of time, so he was not seen. IV. Staff interviews The SSD was interviewed on 10/15/24 at 12:46 p.m. The SSD saidResident #18 requested to be seen by a dentist on 9/19/24 and was not referred to a dentist until 10/4/24. SSD said timely referral was considered to be within a week unless it was an emergency. She said when the dentist was at the facility on 10/10/24, he did not see half of the residents. The SSD said Resident #32 was discharged from the facility to the hospital for surgery and was gone for a few months. She said when he came back from the hospital he was put back on the list to be seen by the dentist. She said she thought he was seen in August 2024. She said she would need to look to see if she was notified of the dental appointment mentioned by the medical doctor in March 2024. The SSD said appointments for ancillary services were posted on the facility's communication board. She said the CNAs should be informing residents when the dentist was coming to the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 10/15/24 at 5:00 p.m. The DON said ancillary services should be offered to all residents. She said she did not know often residents were referred for ancillary services. She said residents needing to be seen by the dentist should be seen at least every six months. The DON said social services was responsible for scheduling ancillary appointments, along with the interdisciplinary team (IDT) involvement. She said ancillary services should be arranged and scheduled timely. The nursing home administrator (NHA) was interviewed on 10/15/24 at 6:00 p.m. The NHA said social services was responsible for scheduling ancillary services. She said she recognized the SSD needed help to be able to submit referrals and complete her job duties timely. She said ancillary services should be submitted timely. 47960 V. Resident #51 A. Resident status Resident #51, age greater than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included lymphedema, heart disease and obesity. The 9/24/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for dressing and personal hygiene. B. Resident interview Resident #51 was interviewed on 10/9/24 at 9:37 a.m. Resident #51 said she requested to see the dentist in September 2024, on a Friday. She said the dentist came on a Thursday instead and she was not notified or taken to see the dentist. Resident #51 said she still wanted to see the dentist and did not know when or if she was scheduled to see the dentist. C. Record review A 9/5/24 appointment progress note documented Resident #51 was not seen by the dentist on that date and was placed on the reserve list for the next dental visit. -A review of the dental reserve list failed to show documentation of the resident's name on the list to see the dentist at the next visit to the facility. Review of Resident #51's comprehensive care plan, revised on 8/12/24, revealed a care plan focus for ancillary services, to include dental needs. The goal was to provide ancillary services to maintain and improve the residents quality of life as needed or requested. The intervention for oral health was to ensure oral health and prevent dental issues by scheduling regular dental check ups and cleanings. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the October 2024 CPO revealed the resident had physician's orders to see a dentist as needed. D. Staff interviews The DON was interviewed on 10/14/24 at 1:00 p.m. The DON said she was not aware that Resident #51 had requested to see the dentist and would look into why she was not seen. The SSD was interviewed on 10/15/24 at 12:49 p.m. The SSD said the facility was having trouble with dental services from the existing provider and they had been looking for a backup dental provider. The SSD said Resident #51 did not have a dental emergency so she was referred to another dentist. -However, there was no documentation in Resident #51's EMR to indicate a referral to another dentist had been made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 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 housekeeping staff followed proper infection control procedures for cleaning resident rooms; -Ensure residents were assisted with hand hygiene prior to meals; -Ensure glucometers were cleaned appropriately following use; and, -Ensure personal protective equipment (PPE) was worn appropriately and appropriate infection control procedures were followed during wound care for a resident on enhanced barrier precautions (EBP). Findings include: I. Failure to follow proper infection control procedures for cleaning resident rooms A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 10/23/24 from https://www.cdc.gov/handhygiene/providers/index.html, Cleaning your hands reduces the spread of potentially deadly germs to patients. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Cleaning and Disinfecting of Resident Rooms policy, revised August 2013, was received from the nursing home administrator (NHA) on 10/15/24 at 6:37 p.m. It read in pertinent part, Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily, three times per week) and when surfaces are visibly soiled. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Perform hand hygiene after removing gloves. C. Manufacturers guidelines The manufacturer guidelines for the Micro-Kill Q3 disinfectant used by the facility were retrieved on 10/28/24 from https://www.medline.com/media/catalog/Docs/MKT/LITe21856_OTH_MicroKill%20Q3%20Technical.pdf. It read in pertinent part, Micro-Kill Q3 is a concentrated one-step disinfectant formulated for general hospital cleaning and the disinfection of hard, nonporous, non-food surfaces. Micro-Kill R3 is EPA (environmental protection agency) approved for use against SARS-CoV-2 (cause of COVID-19). Requires a three-minute contact time for many bacteria and viruses. Eliminates odors and is fragrance-free. Soft surface spot sanitizer treatment. D. Housekeeping observations On 10/15/24 at 8:40 a.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER], a double occupancy room with EBP in place. HK #1 put on gloves and entered the room. HK #1 sprayed Micro-Kill Q3 disinfectant on the door handle of the residents' room and immediately wiped it off. She proceeded to wipe the overbed table on one side of the room and then the other overbed table on the other side of the room. HK #1 sprayed, and immediately wiped off, the first resident's walker, fan and dresser then proceeded to wipe the other resident's dresser with the same rag before walking into the bathroom. HK #1 sprayed and immediately wiped the grab bar, the light switch and the towel bar in the residents' bathroom. She walked back to the resident's trash can and removed the trash bag. She put the trash bag in the receptacle on her cart and removed her gloves. Without performing hand hygiene, HK #1 put on new gloves and returned to the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #1 checked the temperature of the residents' refrigerator and went back to her cart to write down the temperature on the log sheet. She went back to the refrigerator and placed the temperature log back in its holder. HK #1 went back to her cart and removed a dirty mop head, put a new dry mop head on the mop and proceeded to dry mop both sides of the room. She put the mop back on her cart, without removing the dirty mop head, her gloves or performing hand hygiene, and retrieved the toilet bowl cleaning wand from her cart. HK #1 went back into the bathroom and cleaned the toilet bowl with the wand. After cleaning the toilet bowl, HK #1 wiped the top of the toilet with a paper towel. She did not spray the top of the toilet with disinfectant. She removed a urine output measuring cup from the top back of the toilet and used the urine-soiled paper towel it was sitting on to wipe the toilet seat and the area where the urine output measuring cup had been sitting. HK #1 sprayed the bathroom mirror with glass cleaner and immediately wiped it off with a paper towel. Then she wiped the sink with a paper towel that was wet with water. She did not spray the area with disinfectant. HK #1 removed the trash from the bathroom and replaced the trash can liner. She removed her gloves and put new gloves on without performing hand hygiene. HK #1 poured disinfectant on the floor and wet mopped the entire room and bathroom. She swept the trash from the pile she made while mopping the floor. HK #1 finished cleaning the room at 8:52 a.m. -HK #1 did not perform hand hygiene before she started cleaning room [ROOM NUMBER]. -HK #1 did not perform hand hygiene between glove changes. -HK #1 did not use separate rags or mop heads for each side of the residents' room or the bathroom. -HK #1 did not clean all of the high touch surfaces in the residents' room. -HK #1 did not allow the disinfectant to remain on surfaces for any amount of time before wiping it off. -HK #1 did not clean the toilet from an area of cleaner to dirtier. -HK #1 did not change her gloves or perform hand hygiene after cleaning the toilet and before cleaning the residents' mirror and sink. On 10/15/24 at 9:10 a.m. HK #2 was observed cleaning room [ROOM NUMBER], a double occupancy room. HK #2 put on gloves and sprayed the bathroom with disinfectant. She returned to the residents' room and sprayed the disinfectant on the first resident's call light and overbed table and immediately wiped them down. She wiped the resident's dresser, the phone, items on the dresser and the top of the refrigerator. HK #2 documented the temperature of the refrigerator then moved to the other side of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Without changing rags or changing gloves and performing hand hygiene, HK #2 sprayed the second resident's overbed table and nightstand and wiped them down immediately. HK #2 dropped the rag on the floor, picked it up and used it to wipe down the bottom of the overbed table and the table the resident's refrigerator was on. She got a new rag at 9:12 a.m. and sprayed the other overbed table and wiped it down immediately, then wiped the resident's shelf and the top of the dresser. HK #2 picked up the second resident's remote for the television but did not wipe it down. She sprayed and immediately wiped down the front of the dresser. HK #2 got a new rag and wiped the second resident's call light, then sprayed, and immediately wiped off, the wall and cable protector near the resident's bed. HK #2 sprayed and immediately wiped down the resident's nightstand, then wiped the light switch. At 9:16 a.m. HK #2 put on new gloves without performing hand hygiene. HK #2 cleaned the residents' toilet with the toilet wand. Without changing gloves or performing hand hygiene, she got a new rag and cleaned the sink with the rag which was wet with water. She dried the sink with paper towels. HK #2 wiped the towel rack and the soap dispenser. She wiped the top of the toilet with paper towels, raised the toilet seat and wiped the toilet with the same paper towels. HK #2 removed her gloves but did not perform hand hygiene and proceeded to spread floor cleaner in the bedroom and bathroom. She mopped the floor of one side of the bedroom without gloves on. After mopping the first side of the room, she put new gloves on, put a new mop head on and mopped the other side of the bedroom and the bathroom floor. HK #2 put another new mop head on and mopped the entire bedroom floor a second time. HK #2 finished cleaning the room at 9:23 a.m. -HK #2 did not perform hand hygiene before she started cleaning room [ROOM NUMBER]. -HK #2 did not perform hand hygiene between glove changes. -HK #2 did not use separate rags for each side of the residents' room or the bathroom. -HK #2 did not clean all of the high touch surfaces in the residents' room. -HK #2 did not allow the disinfectant to remain on surfaces for any amount of time before wiping it off. -HK #2 did not clean the toilet from an area of cleaner to dirtier. -HK #2 did not change her gloves or perform hand hygiene after cleaning the toilet and before cleaning the residents' mirror and sink. E. Staff interviews HK #1 was interviewed on 10/15/24 at 8:52 a.m. HK #1 said she used odor control, Microkill concentration disinfectant for high touch areas, glass cleaner and soap. She said she always sprayed the disinfectant and immediately wiped the surface down. She said she was not aware of any contact time requirements for the cleaning solutions used. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HK #2 was interviewed on 10/15/24 at 9:23 a.m. HK #2 said she had been with the facility for ten years. She said she was trained by the housekeeping manager when she first started. She said she was not aware of any contact time requirements for the cleaning solutions used. The housekeeping supervisor (HKS) was interviewed on 10/15/24 at 9:35 a.m. The HKS said she had been employed at the facility since June 2024. She said she was responsible for training new staff and she also had new staff train with two other housekeepers before they were able to clean on their own. The HKS said the proper way to clean residents' rooms was to perform hand hygiene, put gloves on, take disinfectant and odor control solution and spray the sink, toilet and call light, get the trash and remove it from the room, clean each side of the room separately and with a different rag for each side, sweep each side of the room and clean the bathroom last, mop the entire room using a different mop head for each side of the room, and mop the bathroom last. She said it was important to clean high touch surfaces, such as the call lights, overbed tables, bathroom doorknob, main doorknob, window sills, remote controls for the beds and televisions and light switches. The HKS said the regular housekeeper had called in today (10/15/24) and HK #1 was filling in but she normally worked in the laundry room. The NHA was interviewed on 10/15/24 at 9:42 a.m. The NHA said it was important to clean residents' rooms in a specific manner to prevent the spread of infection. She said each side of the residents' rooms should be cleaned separately and the rooms should be cleaned from the cleanest area to the dirtiest area. II. Failure to ensure residents were assisted with hand hygiene prior to meals A. Observations During a continuous observation of the lunch meal service in the dining room on 10/15/24, beginning at 11:37 a.m. and ending at 12:02 p.m., the following observations were made: At 11:40 a.m. a resident touched the wall and the cart by the door of the kitchen to request coffee. He was directed back to his table. He was not offered hand hygiene. At 11:40 a.m., a resident was sitting at her table with gloves on. The resident was folding utensils into napkins for other residents to use at mealtime. She reached into the bag on her wheelchair and continued folding utensils into napkins without changing her gloves. She touched the straw in her cup and took a drink then continued folding utensils into napkins. -She did not remove her gloves or perform hand hygiene after reaching into her personal bag or touching the straw in her cup. At 11:44 a.m. another resident wheeled himself into the dining room with one of his hands on the wheel of his wheelchair. He gave staff a high five at 11:48 a.m. He was not offered hand hygiene after touching the wheel of his wheelchair. At 11:56 a.m. the resident wrapping utensils into napkins coughed into her glove. She touched her table and then the armrest on her wheelchair before continuing to wrap utensils. -She did not remove her gloves or perform hand hygiene after coughing into her glove. (continued on next page)

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	065034	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Post Acute	4686 E Asbury Cir Denver, CO 80222

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:58 a.m. a female resident was wheeled to her table and shook hands with another female resident. She was not offered hand hygiene. Staff began serving drinks to residents at 12:00 p.m. A male resident reached into the beverage cart and got his own sweetener at 12:01 p.m. Staff began serving food trays at 12:02 p.m. There was a moist towelette provided to each resident but residents were not reminded or encouraged to use the wipes and assistance was not offered or provided to open the towelette package. -None of the residents above were observed performing hand hygiene. B. Staff interviews The director of nursing (DON) and the regional clinical consultant (RCC) were interviewed on 10/15/24 at 5:01 p.m. The DON said residents were provided with wipes or a warm washcloth before meals. She said staff should offer hand hygiene to residents, or at least open the towelette package, for them. The RCC said providing hand hygiene for residents was important to help prevent the spread of infection. 51160 III. Failure to ensure glucometers were cleaned appropriately following use; and, A. Professional reference According to the Basic Nursing third edition, Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022), page 2257-2258, Select and clean a fingerstick site with an alcohol-based (or other antiseptic) pad. Allow the site to dry thoroughly. This helps protect the patient from infection by removing some surface microorganisms. B. Facility policy and procedure The Blood Sampling Capillary Finger Stick policy and procedure dated, September 2014, was provided by the nursing home administrator (NHA) on 10/15/24 at 6:00 p.m. It revealed in pertinent part, Wipe the area to be lanced with an alcohol pledget. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. The Administering Medications policy and procedure dated, April 2019, was provided by the NHA on 10/15/24 at 6:00 p.m. It revealed in pertinent part Staff follows established facility infection control procedures (handwashing, antiseptic technique, gloves, isolation precautions) for the administration of medications. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 10/10/24, beginning at 8:43 a.m. and ending at 10:00 a.m., the following was observed: At 9:02 a.m. licensed practical nurse (LPN) #2 entered Resident #3's room to obtain the resident's blood sugar level with a glucose monitor LPN #2 used a personal hygiene wipe (not an alcohol wipe) to clean the hand of Resident #3 prior to completing a fingerstick for glucose monitoring. LPN #2 proceeded to use the same personal hygiene wipe to clean the glucometer before immediately placing the glucometer back in its plastic storage bag and exiting the room. At 9:07 a.m. LPN #2 returned Resident #3's room with a Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml (milliliters). LPN #2 cleaned the resident's abdominal injection site with a personal hygiene wipe and proceeded to administer the insulin injection to the resident. D. Staff interviews LPN #2 was interviewed on 10/10/24 at 9:25 a.m. LPN #2 said she cleaned Resident #3's fingers with a personal hygiene wipe because an alcohol prep pad could falsely increase the blood glucose reading. LPN #2 said she was instructed to use the personal hygiene wipe by the director of nursing (DON). LPN #2 said the glucometers should be cleaned with an alcohol prep pad after each use. -However, LPN #2 had been observed using a personal hygiene wipe to clean the glucometer after using it to obtain Resident #3's blood glucose level (see observation above). LPN #2 said she used an alcohol prep pad to clean a resident's skin prior to the administration of insulin. -However, LPN #2 had been observed using a personal hygiene wipe, instead of an alcohol wipe, to clean Resident #3's abdomen prior to the injection of the insulin (see observation above). The DON and the regional clinical consultant (RCC) were interviewed together on 10/15/24 at 5:02 p.m. The DON said all the residents at the facility had their own glucometers and did not share. The DON said the glucometers should be cleaned according to manufacturer recommendations. She said the glucometers used at the facility should be cleaned with a bleach wipe, adhering to the manufacturer's recommended dwell time (the amount of time a disinfectant needs to remain wet on a surface to kill germs and achieve the desired level of disinfection). The DON said, prior to performing a finger stick for glucose monitoring, Resident #3's finger should have been cleaned with soap and water or an alcohol prep pad and allowed to dry. The DON said it was important to clean the site prior to the injection in order to prevent infection, bloodborne illness or cross contamination. The DON said LPN should have cleaned the resident's injection site with an alcohol prep pad prior to administering the injection. E. Facility follow up (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 10:45 a.m. a document was provided by the marketing director (MKD) along with the DON. The document was dated 10/10/24 at 10:13 a.m., during the survey. It documented that LPN #2 had been confused regarding cleaning Resident #3's finger for the fingerstick blood sugar and the injection site. The document indicated LPN #2 was educated by the DON regarding the proper procedure after the observation. IV. Failure to ensure PPE was worn appropriately and appropriate infection control procedures were followed during wound care for a resident on EBP A. Professional references The Centers for Disease Control and Prevention (CDC) (2022), Donning and doffing personal protective equipment (PPE), was retrieved on 10/17/24 from: https://www.cdc.gov/niosh/learning/safetyculturehc/module-3/8.html read in pertinent part, Donning means to put on and use PPE properly to achieve the intended protection and minimize the risk of exposure. The gown should fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. The gloves should extend to cover the wrist of the isolation gown. According to the Basic Nursing third edition, Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022), page 1669-1673 read in pertinent part, [NAME] the gown. [NAME] gloves. If you are wearing a gown, make sure that the glove cuff extends over the cuff of the gown. If skin is visible between the gown and the glove, tape the glove cuff to the gown cuff, covering all visible skin. To provide complete protection of hands and wrists, no skin should be visible between the glove and gown. B. Observations During a continuous observation on 10/10/24, beginning at 1:33 p.m. and ending at 2:06 p.m., the following was observed: The assistant director of nursing (ADON) directed the wound care nurse (WCN) and certified nurse assistant (CNA) #1 to don PPE of a gown and gloves prior to entering Resident #45's room, who was on EBP. -They did not perform hand hygiene prior to putting on the PPE. After CNA #1 entered the room, the ADON directed CNA #1 to wash her hands. CNA #1 entered the resident's bathroom, performed hand hygiene and donned new gloves. -CNA #1 had exposed wrists, as her gown sleeve was not tucked inside her gloves. The ADON opened a clean trash liner and stood at the foot of the bed while the WCN performed the resident's wound care. -The ADON's wrists and watch were exposed, as her PPE gown sleeves were not tucked inside her gloves. The ADON directed the WCN to wash his hand multiple times throughout the wound care process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON directed the WCN to sign and date the dressing. Wearing the same gloves he had used to perform the wound care, the WCN reached his gloved hand under his PPE gown to retrieve a marker from his scrub pocket to time and date the dressing. C. Staff interviews The DON said, prior to entering a room with EBP, facility staff should have performed hand hygiene and then donned a gown and gloves. The DON said that wrists, watches and bracelets should not have been exposed while wearing a gown and gloves. The DON said, in order to prevent the potential spread of infection, staff should not reach under a protective gown to retrieve items from their pockets while wearing PPE.