STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Englewood Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3575 S Washington St Englewood, CO 80113	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations and interviews, the facility failed to provide a comfortable and homelike environment in one of four units. Specifically, the facility failed to ensure: -Resident room [ROOM NUMBER], #204, #206, #209, and #212 were in good repair; and, -Baseboards in the common areas on the second floor unit were clean. Findings include: I. Facility policy and procedure The Safe Homelike Environment policy, revised October 2024, was provided by the nursing home administrator (NHA) on 11/8/24 at 10:12 a.m. It revealed in pertinent part, The facility provides a safe, clean, comfortable and homelike environment and allows the resident to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. II. Ensure resident rooms were in good repair A. Observations On 11/4/24 at 2:52 p.m. room [ROOM NUMBER] was observed to have multiple paint chips averaging six to twelve inches on the wall alongside the resident's bed. During a tour of the north 200 hallway on 11/5/24, from 4:05 p.m to 4:25 p.m., room [ROOM NUMBER], #204, #209,and #212 were observed to have multiple paint chips averaging six to twelve inches on the wall between the bathroom and closet. B. Resident interviews (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 was interviewed on 11/5/24 at 2:19 p.m. Resident #24 said the resident rooms needed to be painted. She said she preferred her home to be in good repair. III. Ensure common areas were clean A. Observations During a tour of the second floor of the facility on 11/5/24, from 4:05 p.m. to 4:25 p.m., the baseboards were dirty. The baseboards had several black skid marks. IV. Staff interviews The maintenance director (MTD) was interviewed on 11/5/24 at 4:25 p.m. The MTD said he was responsible for the building's maintenance. He said he did not have additional staff to support the work orders for the building. The MTD said he knew the walls in room [ROOM NUMBER], #204, #206, #209 and #212 needed to be sanded and painted. He said he prioritized repairs that needed to be completed in the empty rooms after the residents were discharged . He said he did not know when the rooms with residents who lived at the facility long-term would be completed. The MTD said knew the baseboards needed to be cleaned. The MTD said he was in a backlog of maintenance tickets. The NHA was interviewed on 11/6/24 at 3:31 p.m. The said the facility started a repaint project about a month ago. He said he knew the walls in the resident rooms needed to be sanded and painted. He said he knew the baseboards in the hallway needed to be cleaned. He said the maintenance department prioritized the empty rooms after the residents were discharged . The NHA said he did not have a plan on how maintenance could paint the rooms with residents who lived at the facility long-term. The NHA said he realized his current paint project failed to include how to paint all of the resident's rooms including the rooms that were occupied.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41032

Based on interviews and record review, the facility failed to thoroughly investigate resident-to-resident allegations of physical abuse and staff-to-resident allegations of neglect of care to prevent further instances of abuse and residents from feeling neglected for two (#60 and #18) of four residents out of 40 sample residents.

Specifically, the facility failed to:

-Develop a care plan focus for Resident #18, who had a known history of aggressive behaviors towards others and a history of discharge from other facilities due to aggressive behavior;

-Gather all pertinent unbiased observations to identify pertinent facts of the events that occurred before, during and immediately following the incident to determine necessary interventions to prevent further abuse. This could include but not limited to observations of the assailant's behavior; words; gestures; facial expression; demeanor; tone and volume of voice; proximity and assailant and victim during the incident; and other applicable details and responses of each resident;

-Investigate the extent and medical implications of the assailant's alleged hallucinations to determine if they could occur in other settings including common areas of the facility if the resident fell asleep or experienced similar conditions that occurred during this reported incident on 9/24/24; and,

-Complete thorough investigations of the alleged violation of resident-to-resident physical abuse between Resident #18 towards Resident #60 that included sufficient evidence to allow the nursing home administrator (NHA) to determine what actions were necessary to protect the victim, Resident #60, and others residents in the facility from potential abuse by Resident #18 when in common areas of the facility.

Findings include:

I. Facility policy and procedure

The Abuse Prevention of and Prohibition Against Policy, revised October 2024, was provided by the NHA on 11/04/24 at 9:00 a.m. It read in pertinent part, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

All identified events are reported to the administrator immediately.

A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse.

All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the administrator or his/her designee;

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview will be conducted with staff members (on all shifts) who may have information regarding the alleged incident. Interviews will be conducted with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident. The investigation will include the following: -An interview with the person(s) reporting the incident; -An interview with the resident(s); -Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; and, -A review of the resident's medical record, including a review of all circumstances surrounding the incident. At the conclusion of the investigation, the facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation has occurred. The investigation, and the results of the investigation, will be documented. If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves another resident, the facility will continue to assess, monitor and intervene as necessary to maximize resident health and safety. At the conclusion of the investigation, the facility will take action, as necessary, in light of the information gathered, which may include but is not limited to: -If the allegation is substantiated, analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred, and determining what changes are needed to prevent further occurrences; and, -Defining how care provision will be changed and/or improved to protect residents receiving services, if appropriate II. Resident to resident allegation of physical abuse towards Resident #60 by Resident #18 on 9/24/24 A. Facility investigation 1. Description of the incident The facility investigation, dated 9/25/24, revealed that nursing staff found Resident #18 standing over Resident #60 who was in bed. Resident #60 was holding on to Resident #18. The nurse separated the two residents. The responding nurse was not sure of what had occurred at the time of the intervention. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, in Resident #18's electronic medical record (EMR), dated 9/24/24 at 10:30 p.m. and written by the responding nurse, revealed that the nurse went to Resident #60 and Resident #18's room to answer the call light. Upon entering the room, the nurse observed Resident #60 sitting on the side of his bed holding on to the wrist of Resident #18. The nurse separated the two residents and took Resident #18 to the bathroom. -The nursing note failed to provide an assessment of Resident #18's cognitive status or assess his state of mind other than he was calm and cooperative as he was separated from Resident #60. There was no indication if the resident was assessed for consciousness or other altered state of mind as he was observed standing over Resident #60. 2. Witness statements Resident #60 was interviewed by staff just after the incident. Resident #60 said he woke up to find Resident #18 standing over him punching him in the left cheek with a closed fist. Resident #60 said he pushed Resident #18 off of him and held him by the wrist until the nurse was able to remove him. Resident #18 was interviewed by staff just after the incident. Resident #18 said he did not know what was going on and he did not have a problem with his roommate so he must have been hallucinating. A nursing note, dated 9/24/24 at 10:30 p.m., documented that Resident #18 was unable to tell the responding nurse what had occurred and that he did not know why he did that or what he did. Resident #18 said he did not mean it and apologized to Resident #60 several times then said I must have been hallucinating. The residents were moved to separate rooms pending an investigation. -There was no documentation in the investigative report indicating that the investigator asked the responding nurse for detailed information on the exact words of the residents involved or if she had any indication that Resident #18 might have been in an altered state or appeared to have been hallucinating at the time of discovery. There was no indication of which resident turned on the call light or why the call light was turned on in the first place. B. Resident #60 (victim) 1. Resident status Resident #60, age 68, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included cognitive communication deficit, generalized muscle weakness and acute respiratory disease. The 10/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident did not display aggressive behaviors. The resident had a full range of motion (ROM) in the upper extremities (arms) and limited ROM in the lower extremities (legs). He used a manual wheelchair to get around the facility but was able to stand and transfer himself. 2. Resident interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #60 was interviewed on 10/7/24 at 10:30 a.m. Resident #60 said his old roommate punched him and he was glad he had a new roommate. 3. Record review A progress note dated 9/25/24, documented that the interdisciplinary team (IDT) reviewed the resident-to-resident physical altercation that occurred on 9/24/24 and all details in the investigative report (see above). The IDT determined the room move to separate the living situation of the two residents was sufficient to prevent further incidents for Resident #60. -The progress note had no determination of the root cause of the incident and no recommendations for preventing future incidents. -There was no additional information in the resident's EMR from what was in the facility investigation (see above). C. Resident #18 (assailant) 1. Resident status Resident #18, age 67, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included anxiety, depression and cerebral infarction (stroke caused by brain tissue death). The 8/1/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. Resident #18 required partial to moderate assistance from staff for bathing, dressing, transfers and bed mobility. He used a wheelchair for mobility. The MDS assessment did not indicate Resident #18 had hallucinations, delusions or aggressive behavior. 2. Resident interview Resident #18 was interviewed on 11/5/24 at 3:00 p.m. Resident #18 said he did have an altercation with another resident a long time ago. Resident #18 said he hit the other guy, who was his roommate at the time of the altercation. Resident #18 said he was hallucinating at the time. He said he got along with everyone now and he had his own room. 3. Record review -The comprehensive care plan, initiated 4/9/24, did not have a care focus to address Resident #18's history of aggressive behavior prior to the resident-to-resident alteration on 9/24/24. Following the resident to the resident altercation, Resident #18 was prescribed risperidone (an antipsychotic medication) on 9/25/24 for the diagnosis of aggression. A care plan was initiated for the antipsychotic medication and the incident (resident-to-resident altercation) on 9/26/24. (continued on next page)

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SUMMARY STATEMENT OF DEFICIENCIES
(Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-However, the care plan interventions for resident-to-resident altercations only provided interventions for the 72-hours post-incident and did not provide staff with interventions for the possibility of future resident-to-resident altercations.

-There was no intervention for staff to monitor the resident for hallucinations as a precursor to aggressive acts towards their residents.

The 9/10/24 psychiatric nurse practitioner follow-up note revealed Resident #18 had not been experiencing hallucinations but had a history of aggression and had been asked to leave previous long-term care facilities for his behavior.

-However, there was no evidence in the resident's record that the facility addressed this assessment or that they care-planned the resident's history of aggression.

According to the 9/24/24 nursing progress note, nursing staff found Resident #18 standing over the bed of Resident #60. The other resident said Resident #18 hit him on the left side of the face with a closed fist. Resident #18 was unable to tell staff what happened or why he would have hit the other resident. Resident #18 said he may have been hallucinating.

The 9/26/24 physician's progress note documented Resident #18 had been hallucinating often, was combative with staff and was likely experiencing terminal agitation due to end-stage liver disease.

-However, the nursing progress notes for September 2024 did not include any documentation about Resident #18 being combative with staff or hallucinating.

D. Staff interviews

The director of nursing (DON), the social services director (SSD), the social services consultant (SSC) and the NHA were interviewed together on 11/7/24 at 2:30 p.m. The NHA, the SSC and the DON said that they did not substantiate the allegation of abuse for the resident-to-resident altercation between Resident #18 and Resident #60 because neither of the residents were injured and neither were fearful. The DON said the IDT reviewed the incident and since Resident #18 said he was hallucinating, the IDT determined Resident #18's actions were not intentional.

The DON said she had the staff assist Resident #18 to move to a different room on the second floor while Resident #60 stayed in his room and no longer had a roommate. She said both residents were happy with their new living arrangements.

The NHA and the DON said they did not think of considering Resident 18's hallucination as a potential trigger for committing aggressive acts towards other residents whom he might encounter in the common areas of the facility.

The DON said Resident #18's physician examined him after the incident and determined aggression had occurred. The DON said the physician ordered risperidone, to help him control his aggressive 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said following the allegation/incident of physical abuse, the IDT implemented interventions for increased monitoring of Resident #18 that included daily visits from social services to assess the resident for risk of aggression and 15-minute checks by nursing staff to ensure he remained calm. She said these interventions remained in place for 72 hours after the incident occurred. She said, in that time, facility staff did not see any evidence of repeated aggression, so the monitoring interventions were considered completed. 50853

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure the minimum data set (MDS) assessment accurately reflected residents' status based on the criteria outlined in the resident assessment instrument (RAI) for three (#15, #36 and #63) residents out of 40 sample residents. Specifically, the facility failed to: -Ensure the MDS assessments for Resident #15 and Resident #36 accurately documented that the residents had a preadmission assessment screening and resident review (PASRR) Level II qualifying diagnosis; -Ensure the MDS assessment for Resident #15 accurately documented the resident was receiving hospice services; and, -Ensure the MDS assessment for Resident #63 accurately documented the resident was receiving dialysis. Findings include: I. Professional reference According to the American Association of Post-Acute Care Nursing (AAPACN) The Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Process (October 2023), retrieved on 11/12/24 from https://www.aapacn.org/resources/rai-manual/, The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. The MDS assessment is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which formed the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. II. Resident #15 A. Resident status Resident #15, age 72, was admitted on [DATE]. According to the November 2024 computerized physician's orders (CPO), diagnoses included bipolar disorder, manic severe with psychotic features, major depressive disorder and anxiety. The 8/22/24 MDS assessment documented that the resident was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Additionally, there was no MDS assessment that accurately documented that the resident was receiving hospice service while a patient of the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The comprehensive care plan, initiated 8/30/2020 and revised 5/16/23, documented a care focus for psychosocial conditions, as well as mood and behavior. The care plan revealed that the resident had a PASRR Level II diagnosis of major depression and an extensive history of psychiatric treatment. -However, the MDS assessment failed to document the resident's PASRR Level II diagnosis. A review of the resident's electronic medical record (EMR) revealed that the resident was admitted to hospice services on 8/24/24. -However, the MDS assessment was not updated to reflect hospice services were being provided for the resident. III. Resident #36 A. Resident status Resident #36, age 82, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included bipolar disorder, manic severe with psychotic features, moderate depression and anxiety. The 9/25/24 MDS assessment documented that the resident was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. B. Record review The PASRR Level II assessment, dated 1/26/2020, revealed that Resident #36 was diagnosed with bipolar disorder before 2018. The assessment review documented in pertinent part, Based on the Level II evaluation, the state mental health authority has determined that the individual meets the criteria for a PASRR mental illness. The comprehensive care plan, initiated 10/11/18 and revised 1/20/24, documented a care focus for mood and behavior. The care plan revealed that the resident was reassessed for a PASRR Level II and the resident had a qualifying diagnosis for PASRR Level II. -However, the MDS assessment failed to document the resident's PASRR Level II diagnosis. IV. Resident #63 A. Resident status Resident #63, under the age of 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included dependence on renal dialysis, and chronic kidney disease stage 5. -However, the 9/25/24 MDS assessment failed to accurately document that the resident was receiving dialysis while a patient of the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews The social services director (SSD) and the social services consultant (SSC) were interviewed together on 11/6/24 at 2:14 p.m. The SSD said she completed the MDS sections on hearing, speech and vision, cognition, mood, behavior, participation in assessments, state-specific and care area summary and the minimum data set coordinator (MDSC) or nursing staff completed the rest of the MDS assessment. The SSD said when a resident entered with a PASRR Level II diagnosis, she would notify the MDSC who completed the relevant section and the MDSC was responsible for accurately documenting the resident's PASRR level status. The SSD said the nursing staff and the MDSC were responsible for assessing the resident for medical diagnoses and services and making sure the MDS assessment was accurately documented for medical concerns and services. The MDSC was interviewed on 11/8/24 at 2:18 p.m. The MDSC said when completing the initial, quarterly, and significant change MDS assessments, she started by reviewing the resident's EMR to make sure entries to the MDS assessment were accurate. The MDSC said she reviewed the entire MDS assessment for accuracy and a registered nurse signed off on her work. The MDSC said she got resident PASRR information from the SSD, along with other updates and changes in resident care, in the morning meeting with the leadership team and then would update the MDS assessments as required. The MDSC said she had been on an extended leave so she was not sure why Resident #15, Resident #36 and Resident #63's MDS assessments were not accurate. The MDSC said she would work with the corporate MDS consultant to get the MDS assessments corrected with accurate information.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to refer one (#20) of one resident reviewed out of 40 sample residents to the appropriate state-designated authority for Level II preadmission screening and resident review (PASRR) evaluation and determination for services. Specifically, the facility failed to: -Ensure Resident #20 was properly assessed on the PASRR Level I screen to gain and maintain their highest practicable medical, emotional and psychosocial well-being; and, -Submit a new PASRR Level I on three separate occasions when Resident #20 received qualifying mental illness diagnoses. Findings include: I. Professional reference According to John Hopkins Institute, Mood Disorders Overview, (reviewed 2024), retrieved on 11/19/24 from https://www.hopkinsmedicine.org/health/conditions-and-diseases/mood-disorders#:~:text=A%20mood%20disorder%20is%20a%20class%20of%20serious%20mental%20illnesses, can%20all%20have%20mood%20disorders, Mood disorders are serious illnesses. They are likely caused by an imbalance of brain chemicals. A mood disorder can negatively affect your ability to function normally. It can have serious consequences in all aspects of life, from personal to professional. The F39 diagnosis code represents an unspecified mood (affective) disorder. This is a broad category for mood disorders that do not meet the full criteria for a more specific mood disorder, like major depressive disorder or bipolar disorder. It can vary in severity and may or may not involve psychotic features. II. Facility policy and procedure The facility's PASRR policy was requested on 11/7/24. The director of nursing (DON) said the facility did not have a related policy and followed the regulation guidance for PASRR submissions. III. Resident #20 A. Resident status Resident #20, age 74, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included anxiety disorder, depression and mood affective disorder. The 4/8/24 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 assessment indicated the resident did not have a serious mental illness diagnosis and did not meet the criteria for a Level II PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident had active diagnoses of anxiety disorder, depression and unspecified affective mood disorder. B. Record review The Initial Admission Record assessment dated [DATE] documented the resident was receiving psychotropic medication. Resident #20's pre-admission PASRR Level I screening questionnaire, undated, documented the resident had no known or suspected diagnosis of a major mental illness and no signs or symptoms of a major mental illness. -However, the resident was admitted with diagnoses of anxiety disorder, depression and unspecified affective mood disorder (see resident status above). The PASRR Level I notice of determination (NOD), dated 4/4/24, documented the following in pertinent part, Determination: approved. Determination Reason: no Level II required The review of the submitted PASRR Level I Screen resulted in a finding of no known or suspected mental illness, or intellectual/developmental disability, or related condition. If the member's status changes or new information is acquired that provides evidence of a known or suspected PASRR condition as noted above, the facility should resubmit a new PASRR Level I. -However, the facility failed to include Resident #20's diagnoses of anxiety disorder, depression and unspecified affective mood disorder as potential qualifying mental illness diagnoses when the initial PASRR Level I was submitted. The Psychotherapeutic Medication Review Committee note dated 7/9/24 documented the resident received a new prescription for Abilify (an antipsychotic medication) for major depressive disorder. -However, the facility failed to submit a new Level I PASRR when the resident was diagnosed with major depressive disorder on 7/9/24. A social services assessment dated [DATE] documented Resident #20 had a history of anxiety disorder and depression. The resident scored a 15 out of 27 on her last Patient Health Questionnaire-9 (PHQ-9) assessment (a screening tool that helps diagnose and monitor depression) which indicated the resident had moderately severe depression. A medical note dated 9/26/24 revealed the resident had a history of psychiatric conditions including depression, anxiety and post-traumatic stress disorder (PTSD) and had past psychiatric hospital admissions. The resident was diagnosed with recurrent major depressive disorder with psychotic features. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility failed to submit a new Level I PASRR when the resident was diagnosed with recurrent major depressive disorder with psychotic features on 9/26/24. The Interdisciplinary Team (IDT) Care Plan Review document dated 10/30/24 documented that the resident was assessed to have a moderately severe mood disorder and was being followed by behavioral health for a psychiatric condition. -However, the facility failed to submit a new Level I PASRR when the resident was diagnosed with moderately severe mood disorder on 10/30/24. IV. Staff interviews The social services director (SSD) and the social services consultant (SSC) were interviewed together on 11/6/24 at 2:14 p.m. The SSD said PASRR assessments were completed upon admission and with a change of condition in mental health. She said the need for a PASRR Level II assessment was triggered if the resident had a diagnosed major mental illness. The SSD said the PASRR Level II assessment would review the resident's mental health history and current condition and provide the facility with treatment recommendations to ensure the resident's mental health condition was properly treated. The SSD said, upon a resident's admission, she would review the resident's admission intake information and complete a PASRR Level I questionnaire for submission to the state mental health authority. The SSC said she was not sure if Resident #20's diagnosis of unspecified mood adjustment mood disorder would be considered a major mental illness but the PASRR oversight agency should have been notified of the diagnosis for their consideration and possible care and treatment recommendations. The SSD said she would resubmit a new PASRR Level I assessment to the state mental health authority for Resident #20.

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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 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** 50853 Based on observation and interviews, the facility failed to ensure that services provided met professional standards of quality for one (#21) of one resident out of 40 sample residents. Specifically, the facility failed to: -Ensure medications were not left unattended on top of the medication cart; and, -Ensure medications were not left unattended in Resident #21's room. Findings include: I. Professional reference According to the National Library of Medicine Nursing Pharmacology (Internet). 2nd Edition, Chapter 2: Legal/Ethical, retrieved on 11/13/24 from https://www.ncbi.nlm.nih.gov/books/NBK597872/, Use medicines safely: do not leave medications unattended. II. Facility policy and procedure The Medication Access and Storage policy, dated August 2024, was provided by the director of nursing (DON) on 11/7/24 at 5:45 p.m. It read in pertinent part, It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature control. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members legally authorized to administer medication. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medication are allowed access to medications. The medication rooms, carts and supplies are locked or attended by persons with authorized access. III. Resident status Resident #21, age greater than 65, was admitted to the facility on [DATE]. According to the computerized physician orders (CPO), diagnoses included renal (kidney) failure, dementia, anxiety and depression. The 8/20/24 minimum data set (MDS) assessment revealed Resident #21 had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. IV. Observations (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 4:24 p.m. registered nurse (RN) #1 was administering medication to residents on the second floor south hall. RN #1 prepared four pills (famotidine, gabapentin, magnesium oxide and propranolol) in a medication cup for Resident #21 and removed a bottle of eye drops and a tube of Aspercreme from the medication cart. She moved the cup of pills and the eye drops to the back of the cart behind her computer screen and left the Aspercreme on the front of the cart. All of the medications were on top of the medication cart, unsecured. -RN #1 left the medication cart and went to retrieve applesauce from the dining room. The cart was out of her sight during this time and the medications remained on top of the cart, unsecured. After approximately one minute, RN #1 returned to the medication cart and took the pills, eye drops and applesauce to Resident #21's room at the end of the south hall. -RN #1 left the Aspercreme medication behind, on top of the medication cart unattended. A cognitively impaired resident was observed wheeling his wheelchair near the unattended medication cart and another resident walked by the unattended medication cart on his way to the dining room. RN #1 took Resident #21's pulse with the pulse oximeter (a small device that measures oxygen saturation in the blood and pulse) and obtained a reading of 59 beats per minute (bpm), below the parameter to give the resident's propranolol (blood pressure medication). RN #1 said she needed to get her stethoscope to recheck the pulse and left the resident's room. -RN #1 left the medication cup of pills and eye drops unattended in the room with Resident #21 and her roommate. RN #1 walked back down the hall to the nurse's station and returned with a stethoscope, after approximately two minutes. She rechecked the resident's pulse manually, obtained a count of 61 bpm and proceeded to administer Resident #21's medications and eye drops. V. Staff interviews RN #1 was interviewed on 11/5/24 at 4:35 p.m. RN #1 said she forgot the Aspercreme medication was on top of the cart and she should not have left it unsecured and unattended. RN #1 said she should not have left the prepared medications unattended on the medication cart when she went to get the applesauce from the dining room. RN #1 said she moved the cup of medications out of sight, behind her computer, but she should have taken them with her when she left the cart unattended. RN #1 said she should also not have left the medications unattended in Resident #21's room. RN #1 said she should have taken the medications with her when she went to get her stethoscope. The DON was interviewed on 11/7/24 at 12:03 p.m. The DON said medications should not be left unattended on the medication cart or in a resident's room.

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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 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** 50853 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of four hallways. Specifically, the facility failed to: -Ensure appropriate infection control practices were followed during wound care; and, -Ensure housekeeping staff followed appropriate hand hygiene practices and disinfectant dwell times when cleaning residents' rooms. Findings include: I. Failure to ensure housekeeping staff followed appropriate hand hygiene practices and disinfectant dwell times when cleaning residents' rooms A. Facility policy and procedure The Infection Control Housekeeping policy, dated April 2024, was provided by the director of nursing (DON) on 11/7/24 at 5:45 p.m. It read in pertinent part, It is the policy of this facility to provide effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites (objects likely to carry infection). Frequent cleaning of the facility's interior will aid in physically removing some of the micro-organisms which might cause these hazards. Personnel working in resident areas will follow strict hand washing procedures. B. Manufacturer's recommendations The manufacturer's recommendations for Comet Professional Multi-Purpose Disinfecting Cleaner with Bleach was provided by the housekeeping supervisor (HSKS) on 11/7/24. The recommendations indicated the product should be left on surfaces for one minute in order to properly disinfect the surface. The manufacturer's recommendations for Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant were provided by the HSKS on 11/7/24. The recommendations indicated the product should be left on surfaces for 30 seconds to properly disinfect the surface. C. Observations During a continuous observation on 11/6/24, beginning at 9:38 a.m. and ending at 10:00 a.m., the following was observed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeper (HSKP) #1 was cleaning room [ROOM NUMBER], a double occupancy room with only one resident residing on side one of the room. HSKP #1 sprayed the toilet and sink with Comet Professional Multi-Purpose Disinfecting Cleaner with Bleach and said she would let that sit while she cleaned other parts of the room. HSKP #1 sprayed the over bed table and nightstand with Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant and immediately wiped both surfaces with her rag. -HSKP #1 did not allow the Clorox disinfectant to sit for at least 30 seconds, which was the manufacturer's required dwell time for disinfecting surfaces (see manufacturer's recommendations above). HSKP #1 sprayed the trash can with the Clorox disinfectant and immediately wiped it down, inside and outside. HSKP #1 got a clean rag from her cart and cleaned the call light, the cord and the television, spraying each item with the Clorox disinfect and wiping them off immediately. -HSKP #1 did not remove her soiled gloves, perform hand hygiene and put on clean gloves when changing rags and moving from the trash can to high touch surfaces. -HSKP #1 did not allow the Clorox disinfectant to sit for at least 30 seconds on the trash can, the call light, the cord or the television. HSKP #1 changed her gloves and began cleaning the bathroom. She sprayed and cleaned the mirror with a glass cleaner. She sprayed the grab bars and chrome on the back of the toilet with the Clorox disinfectant and immediately wiped them off. HSKP #1 opened a package of toilet paper and put it in the dispenser with the same gloves she was cleaning with. -HSKP #1 did not change her gloves and perform hand hygiene before opening the toilet paper and putting it in the dispenser and she did not follow the Clorox disinfectant dwell times. HSKP #1 wiped the top and bottom of the toilet, squirted a toilet bowl cleaner in the toilet and scrubbed it with the toilet brush. -HSKP #1 proceeded to wipe out the sink using the same rag and wearing the same gloves she used to clean the toilet. After cleaning the toilet and wiping the sink, HSKP #1 disposed of her soiled gloves and put on new gloves. -HSKP #1 did not perform hand hygiene before putting on the new gloves. During a continuous observation on 11/06/24, beginning at 10:10 a.m. and ending at 10:22 a.m., the following was observed: HSKP #2 was cleaning room [ROOM NUMBER], a single occupancy room. HSKP #2 sprayed the door handles, light switches, the sink and toilet with Comet Professional Multi-Purpose Disinfecting Cleaner with Bleach. After two minutes, HSKP #2 wiped down the door handles and light switches. She sprayed her rag with the same disinfectant and wiped the night stand, the over bed table, the call light, the bed control and the remote control for the television. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-HSKP #1 did not allow the disinfectant to remain on the surface of the items for the manufacturer recommended dwell time (see manufacturer's recommendations above).

HSKP #1 took a different rag and cleaned the bathroom and toilet. HSKP #2 got the mop and mopped the bathroom, changed mop heads and mopped the bedroom.

-HSKP #2 did not change her gloves or perform hand hygiene after cleaning the bathroom and toilet.

D. Staff interviews

HSKP #1 was interviewed on 11/6/24 at 10:00 a.m. HSKP #1 said she did not know she should perform hand hygiene when changing gloves. She said she only performed hand hygiene when she completed cleaning a room.

HSKP #2 was interviewed on 11/6/24 at 10:22 a.m. HSKP #2 said the Comet disinfectant did not need to sit on surfaces for any certain amount of time and she could wipe it off right away.

The HSKS was interviewed on 11/6/24 at 3:00 p.m. The HSKS said housekeepers should change their gloves between surfaces when cleaning a room, usually three to four times per resident room. The HSKS said staff should perform hand hygiene when changing gloves. The HSKS said the dwell time for the Clorox disinfectant was 30 seconds to one minute. She said staff should leave the disinfectant on high touch surfaces for 30 seconds to one minute before wiping it off. The HSKS said the Comet disinfecting cleaner dwell time was three minutes and staff should leave it on surfaces for three minutes before wiping it off.

-However, according to the manufacturer's recommendations for dwell times (see above), the Clorox disinfectant had a dwell time of 30 seconds and the Comet disinfecting cleaner had a dwell time of one minute.

The DON was interviewed on 11/7/24 at 11:32 a.m. The DON said housekeeping staff should change gloves between surfaces, such as after cleaning the toilet. The DON said staff should perform hand hygiene when changing gloves.

II. Failure to follow appropriate infection control practices during wound care

A. Professional reference

According to the Centers for Disease Control and Prevention (CDC) Clinical Safety: Clean Hands for Healthcare Workers (2/27/24), retrieved on 11/12/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety,:

If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves.

B. Facility policy and procedure

The Hand Washing and Hand Hygiene policy, dated October 2024, was provided by the DON on 11/7/24 at 5:45 p.m. It read in pertinent part,

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on acceptable standards. Use alcohol based hand rub containing at least 62% (percent) alcohol, or alternatively soap and water, for the following situations: Before and after coming on duty, before and after direct contact with residents, before and after handling medication, before performing any non-surgical invasive procedure, before and after handling an invasive device, before donning (putting on) sterile gloves, before handling a clean or soiled dressing or gauze pads, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or body fluids, after handling used dressings or contaminated equipment, after contact with objects in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings and after removing or disposing of personal protective equipment (PPE). The Clean Dressing Change policy, dated October 2024, was provided by the DON on 11/7/24 at 5:45 p.m. It read in pertinent part, It is the policy of this facility to provide wound care in a manner to decrease potential for infections and/or cross-contamination. Set up a clean field on the over bed table with needed supplies for wound cleansing and dressing application. Wash hands and put on gloves, loosen tape and remove the existing dressing, remove gloves pulling inside out over the dressing and discard. Wash hands and put on clean gloves, clean the wound as ordered, wash hands and put on clean gloves, apply topical ointments and clean dressing, mark dressing with initials and date. Discard gloves and disposable items in the trash receptacle and wash hands. C. Observations On 11/6/24 at 8:11 a.m. the minimum data set coordinator (MDSC) was providing wound care to Resident #30. The MDSC brought the wound care supplies into the resident's room and laid the supplies directly on the resident's mattress. -The MDSC did not set up a clean field to put the wound care supplies on. The MDSC took the clean gauze and saline and cleansed the wound. She opened the package of collagen dressing, cut a piece and applied it to the clean wound. -The MDSC did not remove her soiled gloves, perform hand hygiene and put on clean gloves after cleansing the wound and before applying the dressing to the wound. The MDSC completed the application of wound dressings, disposed of the soiled gloves and supplies and performed hand hygiene. D. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDSC was interviewed on 11/6/24 at 8:15 a.m. The MDSC said she forgot to prepare a clean field for her wound supplies and should not have set them on the resident's mattress. The MDSC said she should have removed her gloves and performed hand hygiene before putting on clean gloves after cleansing the wound and before opening and applying the dressings to the wound. The DON was interviewed on 11/7/24 at 11:32 a.m. The DON said clean supplies for wound care should be placed on a clean area near the resident. The DON said staff should change gloves and perform hand hygiene after cleaning a wound and before applying the dressings.