STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, interviews, and record review, the facility failed to provide a clean, comfortable and homelike environment for 27 of 27 residents in two of two hallways on the secure unit and one of eight residents reviewed on the rehabiliation unit. Specifically, the facility failed to: -Ensure resident rooms were in good repair, blinds were maintained and doors in good condition; -Ensure common areas and the dining room such as walls and baseboards were cleaned and maintained in good repair in the secure unit; -Ensure resident rooms and closet space was labeled appropriately; and, -Ensure resident common area furniture was in good condition. Findings include: I. Observation of the secured unit On 3/17/24 an initial tour was conducted in the secure unit from between 3:00 p.m. and 4:30 p.m. The secure unit consisted of two hallways with resident living areas where 27 residents occupied 17 rooms and were connected by a main hallway with a common area, dining room and the main entrance from outside to the secure unit itself. The following conditions were observed in common areas and resident rooms during the initial walkthrough and throughout survey from 3/17/24 to 3/21/24. Resident hallways and common areas: -The hallway baseboards throughout the facility had multiple areas of peeling paint and pieces of the wood chipped away. Flakes of dried, chipped paint one-fourth to one-half inch in size were scattered in the hallways in front of resident rooms on the women's hallway. -Numerous splatters of white paint were present on the hallway floors. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adjacent hallway corners were scuffed, uneven and were missing fragments that exposed layers of gray, yellow and white paint. -There were six long pink drip stains that ran down the wall from the handrail to the wood baseboard near the men's hallway. -Multiple brown splatters covered an area approximately two feet long and six inches high on the wall above the baseboard near the women's hallway. -A large piece of paint approximately two by three inches was peeling from the door frame of room number five. -A square inch of yellow colored splatter was visible on the wall outside the shower room. -The men's and women's hallways were devoid of any wall decoration. -A handrail approximately twelve inches long on the women's hallway was connected to the wall by two brackets with two screws each. One of the bracket's screws were not secured to the wall and the handrail lifted approximately one inch when moved. -A light brown chair in the common area was cracked and the surface of the chair's headrest worn away so it was black instead of light brown. Residents sat in the chair throughout the survey. -A corner of the metal baseboard heater in the dining room was bent and protruding. The bent corner was under a dining room chair and near residents' feet while resident dined in the dining room. -A grass patio space outside the front entrance of the secure unit building and was accessed freely by secure unit residents through the front doors. The front doors opened to a small outdoor concrete patio that residents and staff passed through during the day. There were eight cigarette butts on the concrete patio 3/18/24 to 3/21/24. Next to the cigarette butts were numerous black burn marks on the concrete, and approximately four feet above the cigarette butts on the brick wall of the building entrance. Staff were observed entering and exiting the front doors of the building numerous times throughout the survey. On 3/20/24 residents participated in a staff led activity on the grass patio space next to the front doors with the cigarette butts still on the concrete patio. Resident rooms: -The doors to the residents' rooms had clear pieces of tape stuck to the doors, multiple spots of leftover tape residue and numerous scuff marks and scratches. -Room number four had a window with a set of blinds that had approximately a dozen missing end pieces near the braided ladders of the blinds. -room [ROOM NUMBER] had two windows each with a set of blinds. Both sets of blinds have multiple bent and broken pieces as well as missing ends of the blinds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had two name labels taped to the door, one was laminated yellow paper and the other was laminated orange paper, both approximately two by six inches wide. Multiple other resident rooms had no resident name signs of any kind. -room [ROOM NUMBER] had a yellow two inch by two inch post it note taped to the door and written in red marker was #20 and the resident's first name. The yellow paper was taped to the door with a four inch long piece of clear tape. room [ROOM NUMBER] on the secure unit: -The four drawer dresser had a drawer with a missing handle. -The closet shelf had a name written on it with black marker and another name attached by a yellow label with white letters. -room [ROOM NUMBER] had two windows with blinds in each window. Both sets of blinds have missing ends. II. Resident interviews and additional observation The resident in room [ROOM NUMBER] of the secure unit was interviewed on 3/17/24 at 3:30 p.m. He said his dresser and bed (in room [ROOM NUMBER]) were old. Resident #111 said he did not know who the people were whose names were written on his closet shelf, but he thought one of them used to live in room [ROOM NUMBER] and had passed away. Resident #111 said he was unsure how long the handle on his dresser was broken and would like his blinds fixed. The resident in room [ROOM NUMBER]W was interviewed on 3/18/24 at 11:00 a.m. Resident #53 said he wished his blinds were fixed because his room was not dark even with the blinds closed. The missing sections of the blinds still let light in his room. -On 3/18/24 room number nine on the rehabilitation unit was observed at 11:00 a.m. to have seven missing ends of the window blinds. III. Staff interviews The maintenance supervisor (MS) was interviewed on 3/20/24 at 1:30 p.m. The MS said facility staff could put a maintenance request into TELS (electronic maintenance request system) to let him know that the blinds in residents' rooms needed repair. The MS said that it was preferable that closet shelves in resident rooms did not have resident names written on them but staff should instead use a label maker. The MS said he would repaint the shelf in room [ROOM NUMBER] on the secure unit to cover the name written in black marker. The MS said the burn marks on the front wall of the building and pavement were likely done by staff smoking and should be cleaned. He said any facility staff could all clean the interior walls and he would see if the housekeeping staff could clean them. The MS said the facility should be getting new chairs and the items were taken off the walls for the remodel a couple weeks prior. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/24 at 2:33 p.m. the nursing home administrator (NHA) came in through the front door of the secure unit and passed by the cigarette butts on the ground. The NHA said he did not see the cigarette butts at the front door when he entered the building and said he would clean them up. The NHA immediately turned and went to the front door of the secured unit and cleaned the cigarette butts from the front entrance. Certified nurse aide (CNA) #1 was interviewed on 3/20/24 at 2:35 p.m. CNA #1 said she usually asked other staff to put a maintenance request for blinds in TELS but the staff told her the residents would just pull the blinds down. CNA #1 said she had not put a work order into the TELS system herself. CNA #1 said she was unsure who was responsible for putting the resident's name on their closet shelf. CNA #1 said all staff regardless of position could clean the spills off the walls. The assistant director of nursing (ADON) #1 was interviewed on 3/21/24 at 10:30 a.m. The ADON said the resident in room [ROOM NUMBER] on the secure unit did not let people in his room when he first arrived so staff were unable to label his closet. ADON #1 said staff were able to place maintenance requests for blinds in TELS and then maintenance staff could then follow up. DON #1 said she was unaware staff told CNA #1 residents would just pull the blinds down again when she noticed the blinds needed repair. ADON #1 said she was unaware there were cigarette butts at the front entrance of the secure unit but cleaning in the facility was the responsibility of all staff. IV. Facility follow up The MS provided a follow up on 3/20/24 at 2:00 p.m. he asked a housekeeping staff member to clean the drips and splatters on the secure unit walls and that she would let him know if the walls were not cleanable and needed to be painted. The MS pushed in the protruding corner of the baseboard heater so it was flush with the rest of the unit and no longer a hazard.

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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** 47024 Based on interviews, observations and record review, the facility failed to ensure the residents were free from abuse for one (#76) of three residents reviewed for abuse out of 47 sample residents. Specifically, the facility failed to ensure Resident #76 was safe from abuse by an employee. Findings include: I. Facility policy and procedure The Abuse Prevention and Reporting policy, dated 4/2014, was provided by the director of nursing (DON) on 3/18/24 at 8:35 a.m. It read in pertinent part, It is the policy of this facility that residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation. Residents will not be subjected to abuse by anyone, including but not limited to, facility staff. Sexual abuse-nonconsensual sexual contact, including, but not limited to, sexual intrusion or penetration or touching intimate parts or the clothing covering the intimate parts or examines or treats for other than [NAME] fide medical purposes or observes or photographs another persons intimate parts or physical force/threat. Any staff member who has reasonable cause to believe or reason to suspect any situation that may be considered abuse will immediately report to the charge nurse. The staff member will intervene and ensure that the resident is safe. Make sure that all residents are kept safe during the investigation. If a staff member is the assailant, the charge nurse/designee must suspend the employee and escort them out of the building immediately. The charge nurse will assess the situation to determine if any emergency treatment is required. The Administrator/designee will complete the investigation and will notify the suspected assailant and victim or responsible party of the conclusion and any corrective actions implemented based on the investigative findings. II. Facility abuse investigation The abuse investigation report was provided by the DON on 3/18/24 at approximately 1:00 p.m. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The report, dated 2/7/24, documented Resident #76 was found to be involved in a sexual relationship with a former employee. The definition of an at-risk adult is a person with a mental illness. The facility documented the resident was not an at risk adult. The facility unsubstantiated the allegation. Resident #76 was found to be involved in a sexual relationship with an employee. The employee was immediately suspended and later terminated. The investigation included interviews with Resident #76 and all male residents in the facility. The resident interview documented the employee and the resident held hands and kissed on the lips. The employee did not provide a statement. -However, the resident was considered an at risk adult because he was residing at the care facility. III. Resident #76 A. Resident status Resident #76, age under 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen), generalized anxiety disorder, obesity, anemia, chronic pain syndrome, insomnia, chest pain, personal history of COVID-19 and major depressive disorder. The 3/11/24 minimum data set (MDS) assessment revealed the resident had normal cognitive function with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent for oral hygiene, toileting, showering, dressing, personal hygiene, transferring and walking. B. Resident interview and observation Resident #76 was interviewed on 3/18/24 at approximately 11:00 a.m. Resident #76 presented his phone with multiple texts from the staff member, respiratory therapist (RT) #1. Text messages included messages stating that she wanted to kick him in the shin (because the relationship was ending), asking where the resident wanted to meet, she needed to put on makeup and clothes and she thought the resident was ignoring her messages. RT #1 had sent two suggestive photos of herself in a bikini to Resident #76. Resident #76 said he and an employee, RT #1, had a relationship. Resident #76 said in January 2024 RT #1 said that she could go out with him. He said she started texting him. He said RT #1 kissed him on the lips at the end of January 2024 and they went out to eat together on 2/3/24. He said they had gone to the park a few times. He said they had gone out a couple of times. He said RT #1 had sneaked into the facility to see him. He said she would stay with him for an hour to an hour and a half. He said she had told him to erase the messages on his phone. He said RT#1 had parked outside the facility and sent text messages saying she wanted to come in and kick him in the shin because he was making her mad because he would not answer her calls (toward the end of the relationship). He said he told RT #1 that they should not be doing this and he was getting stressed due to the craziness. C. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for cognitive function, revised on 7/16/23, documented the resident was at risk for impaired thought processes related to anxiety. Interventions included engaging in simple, structured activities that avoided overly demanding tasks, keeping routines consistent, trying to provide consistent care givers as much as possible in order to decrease confusion and social services to provide psychological support as needed. The care plan for psychological well-being, revised on 2/15/24, documented the resident was at risk for psychosocial well-being problems related to anxiety, depression, history of trauma, inability to problem solve, ineffective coping and lack of acceptance to current condition. Interventions included allow time to answer questions and to verbalize feelings and perceptions, and fears, consult with social services, behavioral health provider and ombudsman, and offer to continue to participate in the transitions program including discussing alternate placement and sending referrals as needed, and providing logical explanations to paranoid/perseveration. The care plan for mood, revised on 2/15/24, documented the resident was at risk for mood problems related to anxiety, depression and trauma. Interventions included behavioral health consults as needed, puzzles, word searches, walks, discussing current events, and one-on-one conversations. The care plan for preadmission screening resident review (PASRR) level II, initiated on 3/6/24, documented the resident had diagnoses of major depressive disorder and post traumatic stress disorder as documented by the mental health provider. Interventions included assisting with a program of activities that is meaningful and of interest, drawing, exercising, walking outdoors, crafting and journaling. Assist to identify strengths, positive coping skills and reinforce these. IV. Interviews A frequent visitor (FV), with knowledge of the resident, was interviewed on 3/18/24 at approximately 12:35 p. m. The FV said Resident #76 initiated a relationship with an employee. She said even if the resident initiated the relationship the employee had the power and, by law, she was the one in trouble. She said no matter what the resident said the employee was in trouble because he was the resident. She said Resident #76 called her about it and he had shown the employee's texts and pictures to her. She said the employee was fired after the investigation. The director of respiratory therapy (DRT) was interviewed on 3/20/24 at 2:22 p.m. The DRT said RT #1 was having a physical relationship with a resident. He said this was a reportable offense. He said this was a conduct issue. He said RT #1 was suspended immediately. He said he had reached out to RT #1 but she had not returned the calls. He said the relationship was happening at her home too. He said there was no rebuttal from her. He said he had spoken with Resident #76 and he corroborated the allegations. The DRT said Resident #76 had shown him the texts to and from RT #1. The DRT said it was not a one time thing, it was ongoing for weeks. The DON was interviewed on 3/20/24 at 2:44 p.m. She said RT #1 had a relationship with Resident #76. It was a sexual relationship. RT #1 was terminated due to the facility's code of conduct which RT #1 had signed when first hired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services assistant (SSA) was interviewed on 3/20/24 at 4:16 p.m. She said she was not aware of the relationship while it was happening. She said Resident #76 had said they had held hands. It was completely unethical for staff to have a relationship with a resident. She said the staff were in a position of trust, like a teacher and student relationship. She said it was just something that the staff should not do. V. Facility follow-up The nursing home administrator (NHA) provided the following information on 3/22/24 at 2:28 p.m. It read, A sexual relationship cannot be substantiated. Per the facility interview the resident denies any sexual relationship and stated that he and the employee only 'held hands and kissed'. Further, multiple attempts to contact the employee have not been effective and she will not contact the facility. Facility believes the two are in a consensual 'relationship' as they may have held hands and kissed. - This does not meet the criteria of abuse. Resident is a (age of resident) year old male and does not meet the criteria of an at risk adult, he has a BIMS of 15/15. During the survey it was stated that he informed the surveyor that a sexual relationship occurred, this was denied in the facility interviews with him. Despite that interview, resident and employees would still be considered to be in a consensual relationship. The relationship with a resident may be unprofessional, however does not constitute abuse in this case or meet criteria in SOM (state operations manual). Employee was terminated for code of conduct. Facility did report to be compliant with regulation F609 and acted accordingly and followed policy through investigation. -Though the resident and the employee only held hands and kissed, the employee was acting in a role outside of providing care to the resident. The employee acted deliberately while engaging in the relationship with the resident. The employee sent texts and pictures to the resident and sneaked into the facility to see the resident. Though the resident did not have a diminished mental capacity and had the ability to make decisions, the employee was the medical professional. The employee acted outside of the role of a care provider and the relationship was considered abuse due to the employee being in a position of power.

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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** 47024 Based on record review and interviews, the facility failed to ensure a facility initiated discharge procedure was followed for one (#76) of two residents reviewed for discharge out of 47 sample residents. Specifically, the facility failed to follow the appropriate procedure for Resident #76's facility initiated discharge from the facility when he requested an appeal. Findings include: I. Facility policy and procedure The Continuum of Care Discharge or Transfer policy and procedure, revised October 2020, was provided by the director of nursing (DON) on 3/19/24 at 6:05 p.m. It read in pertinent part, It is the policy of this facility to provide the resident with a safe organized structured transfer and or discharge from the facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical and psychosocial well being. Transfer/discharge to other facility (planned) Keep resident/family involved with all discharge planning. Complete discharge instruction form and provide direction to resident/family as needed. Obtain signatures to verify directions. Give copy to resident, place original in chart. The Nursing Home Notice of Involuntary Transfer or Discharge policy, revised April 2018, was provided by the nursing home administrator (NHA) on 3/19/24 at 12:13 p.m. It read in pertinent part, This is a notice for an involuntary discharge or transfer. Date nursing home provided notice and the proposed move; nursing home gave the resident these pages on 3/6/24. Nursing home wants the resident to move on 4/6/24. A nursing home can move a resident 30 days after it gives this page to the resident, provided a safe discharge has been arranged. You have the right to appeal the nursing home decision to transfer or discharge you. Grievance and discharge notices: Resident, resident representative or resident council presents grievance orally or in writing within 14 days of incident or nursing home presents resident or resident's representative with written 30 day notice of discharge. Staff designee confers with persons involved in incident or other relevant persons provides written findings to the complainant within 3 days of receipt of the grievance or discharge notice. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident #76 A. Resident status Resident #76, age under 65, was admitted [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen), generalized anxiety disorder, obesity, anemia, chronic pain syndrome, insomnia, chest pain, personal history of COVID-19 and major depressive disorder. The 3/11/24 minimum data set (MDS) assessment revealed the resident had normal cognitive function with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent for oral hygiene, toileting, showering, dressing, personal hygiene, transferring and walking. B. Resident interview and record review Resident #76 was interviewed on 3/18/24 at 11:12 a.m. He said the facility had given him a 30 day notice of involuntary discharge. He said he was concerned about going out because of the concentrator (for oxygen delivery) and it not being enough. He said he had felt better six months ago but then had pneumonia in January 2024 and respiratory syncytial virus (RSV) in February 2024. He said an incident happened with a female staff member that had been discovered 2/7/24 and now they wanted him to leave (cross-reference F600 for abuse). He said he was worried about pain management. He said he had been working on pain management himself. Resident #76 was interviewed again on 3/18/24 at 4:24 p.m. He said he filled out a grievance form with his desire for an appeal of the 30 day discharge notice. He said he had given the notice to the social services assistant (SSA) by slipping it under the social services door. He said he filed a written notice after he had spoken to the nursing home administrator (NHA). He said he had the nurse on duty sign it and make a copy for him. The resident provided the copy of the grievance form with the desire to appeal the 30 day notice from 3/11/24 at 11:29 p.m. It read in pertinent part, I'm turning in this as a notice that I would like to appeal the decision. I talked with the NHA and he is aware of my decision. I am making sure it is documented in writing. Please give the NHA a copy of this and let me know the decision to appeal. The grievance form was signed by the resident and a nurse on 3/11/24 at 11:29 p.m. Resident #76 was interviewed on 3/20/24 at 10:05 a.m. He said he spoke with the NHA on 3/11/24 at approximately 1:30 p.m. or 2:00 p.m. and informed him that he wanted an appeal. He said that was when he decided he should get it in writing too. He said a second 30 day notice was delivered on 3/19/24 and he had been told not to worry about an appeal. He said he had been informed that he did not need to write an appeal. C. Record review (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for discharge, initiated on 11/23/23 and revised on 2/15/24, documented the resident wished to return/be discharged to a home outside of the facility, the resident was working to obtain disability income and independent housing. Interventions included receiving assistance towards self-reliance for discharge, the resident will demonstrate the ability to contact and work with resources independently, encourage to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear and distress. Prepare and give resident contact numbers for all community referrals. A physician progress note dated 2/22/24 documented a physician review for lower level of care. At this time, the resident would benefit from a more independent structure and would recommend a lower level of care. A medication administration note dated 2/22/24 documented a change of condition. The resident was RSV positive. A medication administration note dated 3/6/24 documented the resident required eight liters per minute of oxygen. A social services note dated 3/6/24 documented a meeting with the resident, OMB, NHA and the DON to discuss overall goals and discharge planning. Reviewed the medical directors documentation related to the recommendation for a lesser level of care. A social services note dated 3/7/24 documented the resident was assessed for assisted living facility placement. The ombudsman (OMB) was present during the assessment. The resident was non receptive. The resident was looking at the floor and fidgeting with his oxygen tubing. A social services note dated 3/11/24 documented the resident said he was not going to tour any more buildings and did not like the location he had toured. He said he would not take his disability application to the Social Security Administration office because he did not have the medical records that were required. The SSA and resident have attempted multiple times to obtain the needed records however the organization that had them had not responded. A physician note dated 3/19/24 documented at the resident's last visit he had slowly increased his activity and had dropped about 36 pounds, was lifting weights and was able to walk about two miles. He had been on six lpm of oxygen, however RSV last month set him back quite a bit. He had not fully recovered and was on eight to 10 lpm of oxygen at rest. He hopes to return to his activity in the near future but currently was unable to do that given his high oxygen requirements. He had a follow up appointment with pulmonary in two days. -The follow up pulmonary note was requested on 3/20/24 during the survey, but the facility failed to provide the note by exit on 3/21/24. A copy of the Nursing Home Notice of Involuntary Transfer or Discharge was provided by the DON on 3/19/24 at 2:04 p.m. it read in pertinent part, This notice is for an involuntary discharge or transfer. Fill out this notice for the resident you want to move. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give these pages to the resident and to his or her representative. Also, send these pages to the State LTC (long term care) Ombudsman and the Local LTC Ombudsman. -The 30 day notice form did not have a receiving facility and was signed by the NHA, had the physician name written in with no signature,and was not signed by the resident. III. Staff interview The social services assistant (SSA) was interviewed on 3/19/24 at 10:17 a.m. She said she did not know how the 30 notice of involuntary discharge worked because she was not part of the discharge planning process for Resident #76. She said the nursing home administrator (NHA) was the only person who could initiate the 30 day discharge process. She said Resident #76 had brought her a concern (grievance) form regarding an appeal. She said she had informed the OMB about the appeal request. She said the resident had fired the OMB; however, that did not stop her from working on the case. The NHA, the DON, and the social services consultant (SSC) were interviewed on 3/19/24 at approximately 1:50 p.m. The NHA said Resident #76 was given the 30 day notice of involuntary discharge on 3/6/24. He said the resident, the NHA, the DON, the OMB and the SSC were in the room. He said the OMB gave the resident the notice. He said the 30 day notice was facility initiated. He said he had not saved a copy of the 30 day notice and the resident had the only copy. He said he had not received the grievance form with the appeal request due to being out of town. He said the SSA should have contacted the OMB with the grievance/appeal form. He said there was an official appeal form but he had not filled it out because he was unaware of the resident's desire to appeal. He said the resolution to the grievance form was filled out on 3/19/24 during the survey. The SSC was interviewed on 3/19/24 at approximately 1:50 p.m. The SSC said the first 30 day notice did not have a facility noted. She said the resident had been informed a new notice would be issued when there was a receiving facility. The social services director (SSD) was interviewed on 3/19/24 at 3:14 p.m. She said grievance forms should be addressed in a timely manner. She said if the administration was not available the grievance/appeal should have gone to the ombudsman. The NHA was interviewed again on 3/19/24 at 3:25 p.m. He said grievances were discussed in the morning meetings and during walking rounds. He said he did not know if it was discussed in the morning meeting due to being out of town. The SSC was interviewed on 3/20/24 at 9:17 a.m. She said the SSA should have contacted the NHA regarding the grievance/appeal form from Resident #76 and then speak to the resident and explain the plan. She said the SSA could have contacted her about the appeal. She said the discharge was an involuntary/facility initiated discharge. She said she had spoken with the NHA on 3/6/24 about the 30 day notice for Resident #76. She said the original 30 day notice did not have a receiving facility listed and after a facility was chosen a new 30 day notice would be issued. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSC said the discharge plan was involuntary due to the resident not wanting to leave. The SSC said she had given the NHA the template for the 30 day notice and the NHA should have kept a copy as well as given a copy to the OMB. She said the 30 day notice form should have the residents, the OMB, the NHA and the physician's signature on it. The NHA was interviewed on 3/20/24 at 10:26 a.m. The NHA said he did not remember having a conversation with Resident #76 about an appeal on 3/11/24. He said the first he knew about an appeal was the form he saw for the first time on 3/19/24. He said he had not had any conversations with the ombudsman about the 30 day notice after giving the resident the original 30 day notice on 3/6/24.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review, and interviews, the facility failed to ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one (#70) of two residents reviewed for dementia care out of 47 sample residents. Specifically, the facility failed to: -Implement wandering interventions as listed on the care plan for Resident #70; and, -Consistently document Resident #70's wandering behavior and interventions used to determine the effectiveness of the interventions. Findings include: I. Facility policy and procedure The Care of Dementia policy, revised July 2023, was provided by the director of nursing (DON) on 3/21/24 at 9:50 a.m. The policy revealed in pertinent part, It is the policy of this facility that all residents will have an individualized plan of care and have the least restrictive approaches to care. Staff are offered specialized trainings in the care of the dementia population, appropriate approaches to care and managing behaviors. The interdisciplinary staff will initiate a thorough clinical assessment. The monitoring of mood, behavior and/or any psychosocial related issues to identify possible underlying medical problems which may be causing behavior problems. The interdisciplinary team will review findings of evaluations and develop a plan of care addressing the resident's needs. II. Resident #70 A. Resident status Resident #70, age 72, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia and bipolar disorder. The 1/5/24 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) was not conducted for Resident #70, and she had a memory problem and was severely impaired. The resident was dependent on staff for oral hygiene, toileting, dressing and personal hygiene and shower/tub transfers; she needed supervision for bed mobility; and supervisor or touching assistance from staff for walking ten feet, 50 feet and up to 100 feet. The MDS assessment marked wandering behavior was not exhibited by Resident #70. B. Observations (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following observations were made on 3/17/23 in the secure unit. At 3:37 p.m. Resident #70 entered room [ROOM NUMBER]. Resident #70 walked across the room to the dresser and picked up the folded bath towel on the dresser. The resident who resided in room [ROOM NUMBER] told Resident #70 no, and he guided Resident #70 toward the door of the room which she exited into the hallway. At 3:39 p.m. Resident #70 entered room [ROOM NUMBER] again and the resident who resided in room [ROOM NUMBER] said to Resident #70, please get out of here, and he guided Resident #70 to the door of the room where she exited into the hallway. -Staff were not present to intervene or redirect Resident #70 from entering room [ROOM NUMBER] and attempting to remove a personal item from room [ROOM NUMBER]. At 4:47 p.m. Resident #70 was sitting in the dining room during dinner service. At 4:57 p.m. Resident #70 walked out of the dining room past four staff members talking to each other. The four staff members continued talking to one another while Resident #70 continued to walk out of sight around the corner of the common area. -Resident #70 was not redirected back to the dining room or offered any food or items of preference as she left the dining room. At 5:01 p.m. Resident #70 was in the dining room. One staff member was present in the dining room passing meal trays to seated residents. Resident #70 attempted to hold another resident's hand. Resident #70 walked to another resident and attempted to grab the resident's walker. The staff member passing trays called out Resident #70's name and then continued to pass trays. Resident #70 continued to ambulate in the dining room. At 5:31 p.m. Resident #70 pushed open the alarmed exit door to the outdoor courtyard at the end of the women's hallway, setting off the exit door alarm. Resident #70 turned around to continue back down the women's hallway. The assistant director of nursing (ADON) walked down the hallway to redirect Resident #70 away from the alarmed door and back to the common area of the building. At 5:47 p.m. Resident #70 opened a door to room [ROOM NUMBER] and entered the room, walked around briefly in the room and then exited the room to continue walking down the men's hallway. -Staff did not see or redirect Resident #70 away from room [ROOM NUMBER] to prevent her from entering another resident's room. At 5:55 p.m. Resident #70 entered room [ROOM NUMBER]. A staff member entered room [ROOM NUMBER] behind Resident #70 and said, Ok we will walk right in and walk right out. The staff member followed Resident #70 into room [ROOM NUMBER] and after Resident #70 exited the room, the staff member exited the room. Two residents were present in room number number 21 when Resident #70 entered and exited the room. -Resident #70 was not offered any kind of activity or snack as an intervention after exiting room [ROOM NUMBER]. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following observations were made on 3/19/24 in the secure unit. At 9:10 a.m. Resident #70 entered room [ROOM NUMBER] on the men's hallway. She walked around inside the room, exited the room and pulled the door closed. -Resident #70 was not observed by staff and there were no interventions that prevented her from entering room [ROOM NUMBER]. At 9:35 a.m. Resident #70 entered room [ROOM NUMBER] on the men's hallway, walked into the room and then exited the room. -Resident #70 was not observed by three staff at the nurses station to prevent Resident #70 from entering another resident's room. At 11:02 a.m. Resident #70 entered room number six for approximately five seconds. Resident #70 then exited the room and continued to walk down the women's hallway. -No staff were present to intervene and prevent Resident #70 from entering another resident's room while the resident who resided in room [ROOM NUMBER] was in her room. At 11:04 a.m. Resident #70 attempted to open the door to room number three but was unable to get the door open. -Two staff members were in view of Resident #70 but did not see Resident #70 open the door and staff did not intervene to redirect Resident #70. At 11:05 a.m. Resident #70 entered room number six, walked around inside the room and exited the room while the resident who resided in room number six was in her room. -No staff were present to intervene and prevent Resident #70 from entering another resident's room. At 11:15 a.m. Resident #70 tried to open the door to room number eight at the end of the women's hallway. She was unable to open the door and continued to walk down the hallway. At 11:22 a.m. Resident #70 attempted to open the door to a resident's corner room on the women's hallway but was unable to get the door open. -Two staff members were at the nurses station in view of the resident but did not observe her attempting to open the door to another resident's room. At 2:41 p.m. Resident #70 pushed open the alarmed exit door to the outdoor courtyard at the end of the women's hallway, setting off the exit door alarm. Resident #70 turned around to continue back down the women's hallway. A certified nurse aide (CNA) redirected Resident #70 back toward the common area and offered her a snack with a snack. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:05 p.m. Resident #70 pushed open the alarmed exit door to the outdoor courtyard at the end of the women's hallway, setting off the exit door alarm. Resident #70 exited through the alarmed door to the outdoor courtyard. After hearing the alarm, three staff members opened the alarmed exit door to redirect Resident #70 back inside the secure unit women's hallway. -Resident #70's wandering behaviors of entering resident's rooms and any interventions if offered by staff were not documented in her medical record. C. Record review Resident #70's elopement care plan, initiated 8/24/22 and revised 5/10/23, documented she was an elopement risk and wanderer due to her wandering behavior and dementia diagnosis; she enjoyed walking throughout the facility and often wandered into other residents rooms and into others personal space. Pertinent interventions included: -Distract Resident #70 from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and document wandering behavior and attempted diversional interventions, initiated 8/24/22. -Identify a pattern of wandering such as wandering purposeful, aimless, or escapist or was the resident looking for something and did the behavior indicate the need for more exercise. Intervene as appropriate, initiated 8/24/22. -Re-direct Resident #70 out of others rooms as needed, initiated 1/17/23. Resident #70's care plan documented she had potential for behavior problems related to her bipolar diagnosis, at times ambulated into other residents' rooms and took their belongings and took belongings that were not hers, initiated 9/07/22 and revised 9/18/23. Pertinent interventions included: -Assist Resident #70 out of other residents' rooms and offer activities of choice, initiated 12/02/22. -Offer to walk with Resident #70 when she invaded others' space, initiated 1/18/23. Resident #70's behavior tracking task in the electronic medical record included wandering behavior. -There were no responses for wandering recorded in the task responses. III. Staff interviews (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 3/20/24 at 2:35 p.m. CNA #1 said staff tried their best to keep residents out of other residents' rooms. She said the resident in room [ROOM NUMBER] yelled for staff nurse when another resident entered his room and he let the staff know if another resident entered his room. CNA #1 said she was not aware Resident #70 entered room [ROOM NUMBER] and attempted to take a towel from the dresser. CNA #1 said staff tried to redirect Resident #70 away from the alarmed exit door and back inside the building because Resident #70 removed her socks often and it was unsafe for Resident #70 to be on the concrete outside without her socks. She said she was not aware Resident #70 had specific interventions on her care plan for wandering. The ADON was interviewed on 3/21/24 at 10:30 a.m. The ADON said the facility tried to schedule more staff on the men's hallway to and redirect residents away from room [ROOM NUMBER] and prevent residents from entering that room. The ADON said staff could monitor the safety mirror positioned in each upper corner of the hallway to monitor hallways when not physically present in the hallway. The ADON said Resident #70's wandering was typical that behavior was not documented, only if her behavior was a safety hazard to herself or others and staff should tell a nurse or use the behavior documenting in Resident #70's chart. She said Resident #70 was expected to wander to the back exit door and staff monitored Resident #70 to redirect her way from the back door for safety reasons. IV. Facility follow up Resident #70's wandering behavior documentation was requested. On 3/22/24 at 2:45 p.m. The facility provided Resident #70's wandering evaluation dated 1/14/24. The wandering evaluation documented Resident's #70's wanderings placed the resident at significant risk of getting to a potentially danger place (outside the facility), wandering was aimless with potential to go outside with active exit seeking behavior, and the wandering significantly intruded on the privacy and activity of others in the last 6 months.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47350 Based on observations, record review and staff interviews, the facility failed to ensure the medication error rate was not greater than five percent. Specifically, the facility's medication error rate was 6.25% with two errors out of 31 opportunities. Findings include: I. Professional reference According to the Humalog Kwikpen (Lispro insulin) manufacturer guidelines, last updated August 2023, retrieved from https://uspl.lilly.com/humalog/humalog.html#ug1 retrieved on 3/25/24 included the following recommendations, Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. II. Facility policy and procedure The Medication Administration policy and procedure, reviewed January 2023, was provided by the nursing home administrator (NHA) on 3/19/24 at 6:06 p.m. It read in pertinent part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. III. Medication administration to Resident #53 On 3/19/24 at 11:00 a.m. registered nurse (RN) #1 checked Resident #53's insulin order of Lispro insulin eight units to be administered before lunch. She obtained his labeled Lispro insulin pen. She then placed a disposable needle onto the Lispro insulin pen. She then dialed eights onto the Lispro insulin pen. She then entered Resident #53's room and administered the insulin. -RN #1 did not prime the pen prior to dialing the dose and administering the insulin. IV. Medication administration Resident #73 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 4:00 p.m. RN #2 checked Resident #73's insulin order of Humalog eight units. She obtained his labeled Humalog insulin pen and dialed eight units of insulin. She administered the insulin to Resident #73 who was sitting at the medication cart. -RN #2 did not prime the insulin pen prior to dialing the dose and administering the insulin. V. Staff interviews RN #1 was interviewed on 3/19/24 at 11:05 a.m. She said insulin pens should be primed when it was a new pen or primed when there was visible air in the pen cartridge. She said she did not prime the insulin pen prior to administration of the insulin. The director of nursing (DON) was interviewed on 3/19/24 at 11:30 a.m. She said insulin pens should be primed with two units of insulin before the dosage was dialed into the pen. She said this was done to ensure the proper dose of insulin was administered. She said she would review with the RNs on how to prime pens prior to administration of insulin. RN #2 was interviewed on 3/19/24 at 4:15 p.m. She said insulin pens should be primed before every administration of insulin to ensure there were no air bubbles in the cartridge or needle and to ensure the correct dosage of insulin was administered. She said she did not prime the pen before administration.

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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** 47350 Based on observation, record review and interviews, the facility failed to ensure that residents were free from significant medication errors for two (#53 and #73) of six residents reviewed for medication errors of 47 sample residents. Specifically, the facility failed to ensure that Resident #53 and Resident #73 was administered the correct dose of insulin by properly priming the insulin pen before insulin administration. Findings include: I. Professional reference According to the Humalog Kwikpen (Lispro insulin) manufacturer guidelines, last updated August 2023, retrieved from https://uspl.lilly.com/humalog/humalog.html#ug1 retrieved on 3/25/24 included the following recommendations, Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. III. Resident #53 A. Resident status Resident #53, age 74, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), the diagnoses included heart disease and diabetes mellitus. The 2/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. He required substantial/maximal assistance with transfers, toileting, partial/moderate assistance with personal hygiene, bed mobility and set up assistance for eating. B. Observations On 3/19/24 at 11:00 a.m. registered nurse (RN) #1 checked Resident #53's insulin order of Lispro insulin eight units to be administered before lunch. She obtained his labeled Lispro insulin pen. She then placed a disposable needle onto the Lispro insulin pen. She then dialed eights onto the Lispro insulin pen. She then entered Resident #53's room and administered the insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN #1 did not prime the pen prior to dialing the dose and administering the insulin. IV. Resident #73 A. Resident status Resident #73, age 79, was admitted on [DATE]. According to the March 2024 CPO, the diagnoses included diabetes mellitus. The 3/4/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. He required setup assistance with eating, personal hygiene, bed mobility, transfers and toileting. B. Observations At 4:00 p.m. RN #2 checked Resident #73's insulin order of Humalog eight units. She obtained his labeled Humalog insulin pen and dialed eight units of insulin. She administered the insulin to Resident #73 who was sitting at the medication cart. -RN #2 did not prime the insulin pen prior to dialing the dose and administering the insulin. V. Staff interviews RN #1 was interviewed on 3/19/24 at 11:05 a.m. She said insulin pens should be primed when it was a new pen or primed when there was visible air in the pen cartridge. She said she did not prime the insulin pen prior to administration of the insulin. The director of nursing (DON) was interviewed on 3/19/24 at 11:30 a.m. She said insulin pens should be primed with two units of insulin before the dosage was dialed into the pen. She said this was done to ensure the proper dose of insulin was administered. She said she would review with the RNs on how to prime pens prior to administration of insulin. RN #2 was interviewed on 3/19/24 at 4:15 p.m. She said insulin pens should be primed before every administration of insulin to ensure there were no air bubbles in the cartridge or needle and to ensure the correct dosage of insulin was administered. She said she did not prime the pen before administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47151 Based on observations, record review and interviews, the facility failed to store, prepare and serve food in a sanitary manner in one of two kitchens. Specifically, the facility failed to ensure dish room sanitation was maintained to eliminate harborage conditions for pests in the secure unit kitchen. Finding include: I. Professional reference The Colorado Retail Food Regulations, effective 3/16/24, were retrieved 3/25/24 from https://cdphe.colorado.gov/environment/food-regulations. The regulations revealed in pertinent part, Physical facilities shall be cleaned as often as necessary to keep them clean. Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing. The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by routinely inspecting incoming shipments of food and supplies; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions. Dead or trapped birds, insects, rodents, and other pests shall be removed from control devices and the premises at a frequency that prevents their accumulation, decomposition, or the attraction of pests. II. Facility policy and procedure The Kitchen Sanitation and Cleaning policy and procedure, revised August 2021, was provided by the dietary manager (DM) on 3/21/24 at 12:30 p.m. The policy revealed in pertinent part, Cleaning should be performed before, during and after food preparation. Each user must properly clean and sanitize the kitchen after their shift and ensure the kitchen is ready for the next user. Floors should be swept and cleaned at the end of your shift. All custodial brushes and equipment must be in good repair. Dirtied walls should be washed with hot soapy water, wiped with clean towels, sanitized and wiped again with clean towels. III. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lunch service was observed and a kitchen walk through was conducted in the secure unit on 3/20/24 from 11:50 a.m. to 12:30 p.m. Observations in the kitchen revealed a cleaning list was not posted or utilized and the facility failed to maintain in good condition and keep the floor and walls under the dish machine clean to prevent pest harborage. The dish machine in the secure unit kitchen was flanked by dish tables on both sides that connected in a 90 degree angle in the corner of the kitchen. The tile walls behind and under the dish machine tables were splattered with brown spots and small pieces of debris. A layer of black dirt and grime with pieces of debris and food crumbs was on the floor under the dish machine and both dish machine tables and extended to the walls. The black vinyl cove base (baseboard) under the clean dish table pulled away from the wall at its top edge in two spaces, approximately one inch long each. An undated pest glue trap approximately three inches long was on the floor under the clean side dish table with approximately 20 small roaches inside. There were two dead and dried roach carcasses next to the pest glue trap on the floor. The black vinyl cove base under the dirty side dish table was completely separated from the wall and when pulled away from the wall half an inch there were two live cockroaches behind the cove base. IV. Staff interviews The DM was interviewed on 3/20/24 at 3:30 p.m. The DM said she was working on a cleaning list for the kitchen but did not have a cleaning list currently in use. The DM said staff cleaned the kitchen floors daily but have not specifically cleaned under the dish machine. The DM said the pest control company came to the facility for scheduled maintenance visits and made additional visits and if the facility called the company. The DM said staff wrote pest sightings in a pest control log and then informed maintenance. The DM said she would add the walls and floor under the dish machine to the cleaning list as an area to be cleaned on a regular basis and deep cleaned. The maintenance supervisor (MS) was interviewed on 3/20/24 at 3:45 p.m. The MS said the pest control company came to the facility on a regular schedule for maintenance. The MS said the pest control company put the pest sticky traps in the area most likely to harbor pests such as under the dish machine. The MS said he was unsure how long the pest sticky trap had been under the dish machine.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to maintain medical records on each resident that were accurately documented for three (#3, #22 and #59) out of four residents reviewed out of 47 sample residents. Specifically, the facility failed to: -Ensure the medical orders for scope of treatment (MOST) form had complete and accurate documentation of who obtained verbal consent from legal decision makers; and, -Ensure timely follow up was completed with a signature from the resident's legal representative. Findings include: I. Facility policy and procedure The Advanced Directives policy and procedure, reviewed [DATE], was provided by the director of nursing (DON) on [DATE] at 6:05 p.m. It read in pertinent part, The resident or responsible party will be asked to fill out and sign a MOST form upon admission indicating their wishes in the event of a health emergency. The resident and/or legal representative shall sign and date the form acknowledging that the options were reviewed and understood. Such documentation shall be maintained in each resident's record. The form will also be signed by the resident's medical provider. Any resident who does not have a signed order or advance directive will be treated as a full code until the order is signed by the resident/responsible party and the provider. II. Resident #3 A. Resident status Resident #3, age 84, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included vascular dementia, diabetes mellitus and hypertension (high blood pressure). The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of one out of 15. He was dependent with personal hygiene, transfers, toileting, required substantial/maximal assistance with bed mobility and set up assistance with eating. B. Record review (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MOST form, dated [DATE] and reviewed on [DATE], revealed the resident wished to receive CPR (cardiopulmonary resuscitation). -The form did not have a mandatory patient or legal decision maker signature. The form had a hand written verbal consent from POA (power of attorney) along the margin without any corresponding signatures of who obtained the verbal consent. III. Resident #22 A. Resident status Resident #22, age 72, was admitted on [DATE]. According to the [DATE] CPO, the diagnoses included Alzheimer's disease and diabetes mellitus. The [DATE] MDS assessment revealed the resident had severe cognitive impairment with deficits in short and long term memory. He rarely ever made decisions regarding daily life. He was dependent with toileting, personal hygiene, bed mobility, transfers and required set up assistance for eating. B. Record review The MOST form, dated [DATE] and reviewed [DATE], revealed the resident wish of no CPR with comfort focused treatment and no artificial nutrition by tube. -The form did not have a mandatory patient or legal decision maker signature. The consent had handwritten verbal consent from POA without corresponding signatures of who obtained verbal consent. IV. Resident #59 A. Resident status Resident #59, age 85, was admitted on [DATE]. According to the [DATE] CPO, the diagnoses included cervical fracture, cerebral infarction (stroke) and dementia. The 2//,d+[DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief BIMS score of 3 out of 15. He was dependent with personal hygiene, bed mobility, transfers, toileting and required set up assistance with eating. B. Record review The MOST form, dated [DATE] and reviewed [DATE], revealed the resident wish of CPR with selective treatment and short term nutrition by tube. -The form did not have a mandatory patient or legal decision maker signature. The consent had handwritten verbal consent from daughter and resident without corresponding signatures of who obtained verbal consent. V. Staff interviews (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 11:30 a.m. She said the nurse completed the MOST forms upon admission. She said if the resident was not able to sign their consent the legal decision maker or POA would sign the form. She said if the legal decision maker was not available to sign the form she said a verbal consent was obtained and the sure signed the form. She said only one nurse needed to sign the form. She said the MOST forms were forwarded to medical records for completion and uploaded into the electronic medical record. The medical records specialist (MRS) was interviewed on [DATE] at 11:35 a.m. She said she ensured the physician signed the MOST forms. She said if there were other missing signatures including from the resident or the legal decision maker she would notify the nursing staff. She said she did not know if verbal consents required two signatures until a formal signature from the legal decision maker or POA could be obtained. The social work consultant (SSC) was interviewed on [DATE] at 9:17 a.m. She said the admitting nurse completed the MOST form upon the resident's admission into the facility. She said during the care conferences MOST forms were reviewed at that time. The recommended practice during the care conference was to make sure the MOST forms were complete and accurately filled out. She said when a verbal consent was obtained for a MOST form two staff members needed to witness the verbal consent and then follow up with their signatures on the form. She said there seemed to be a gap in practice in ensuring those signatures were completed and reviewed during the quarterly care conferences.

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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 - Few	Provide and implement an infection prevention and control program. 47350 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection in one out of two units. Specifically, the facility failed to ensure a glucometer was cleaned in a sanitary manner. Findings include: I. Professional reference Institute for Safe Medical Practices (July 2021). Infection transmission risk with shared glucometers, fingerstick devices, and insulin pens. https://www.ismp.org/resources/infection-transmission-risk-shared-glucometers-fingerstick-devices-and-insulin-pens, retrieved on 3/25/24. Whenever possible, blood glucometers should not be shared. If they must be shared, each device should be cleaned and disinfected after every use, per the manufacturer's instructions. II. Facility policy and procedure The Glucometer Disinfection policy and procedure, not dated, was provided by the director of nursing (DON) on 3/19/24 at 6:05 p.m. It read in pertinent part, Glucometers should be cleaned and disinfected before and after each use and according to manufacturer's instructions, regardless of whether they are intended for single resident or multiple resident use. Glucometers should be disinfected with a wipe presaturated with an EPA (Environmental Protection Agency) registered disinfectant that is effective against HIV (human immunodeficiency virus), hepatitis C and hepatitis B virus. The facility currently uses Medline Micro Kill Bleach wipes, which have been validated by the glucometer manufacturer. III. Manufacturer guidelines Arkray USA, Inc. April 2023. Arkray Technical Brief: Cleaning and Disinfecting the Assure Prism Multi Blood Glucose Monitoring System. https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-prism-multi/, retrieved 3/25/24. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. Only wipes with environmental protection registration (EPA) numbers listed below have been validated for use in cleaning and disinfecting the meter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clorox Germicidal Wipes EPA #67619-12; Dispatch Hospital Cleaner Disinfectant Towels with Bleach EPA #56392-8; Super Sani-Cloth Germicidal Disposable Wipe EPA #9480-4; CaviWipes1 EPA #46781-13 PDI. September 2023. PDI Sani Hands and Sani Professional Hand Sanitizing Wipes Safety Data Sheet. https://pdihc.com/wp-content/uploads/2018/08/SDS-0343-00-English-Rev.7_SaniHands.pdf, retrieved 3/25/24. EPA Pesticide Registration Number not applicable. PDI. 2024. Sani Hands Instant Hand Sanitizing Wipes Instructions for Use. https://pdihc.com/wp-content/uploads/2018/08/Sani-Hands-IFU.pdf, retrieved 3/25/24 Help prevent the spread of infections. Sanitize your hands before eating and after visiting the restroom and after coughing or sneezing. IV. Observations On 3/19/24 at 11:00 a.m. registered nurse (RN) #1 took out from the medication cart a glucometer not labeled for a resident to check Resident #53's before lunch blood glucose. She wiped the glucometer with two PDI Sani Hand wipes. She entered Resident #53's room obtained his blood glucose and disposed of the test strip in the glucometer that contained blood in the sharps container. She returned to the medication cart and wiped the glucometer down with another PDI Sani Hand wipe and placed it in the medication administration cart. V. Staff interviews RN #1 was interviewed on 3/19/24 at 11:03 a.m. She said she wiped down the glucometers before and after and used PDI Sani Hand Wipes. She said the glucometer needed to stay wet for two minutes after using the PDI Sani Hand Wipes. RN #2 was interviewed on 3/19/24 at 4:15 p.m. She said glucometers needed to be wiped down before and after use with Sani Cloth bleach wipes and they needed to stay wrapped for two minutes to stay wet and ensure the proper disinfectant time. The director of nursing (DON) was interviewed on 3/19/24 at 4:32 p.m. She said glucometers needed to be wiped with the bleach wipes or the Sani Cloth Germicidal Wipes. She said they should be wrapped and kept wet for the recommended manufacturer time of two minutes. She said the PDI Sani Hand wipes were not the approved wipes for disinfection of the glucometer.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review, observations and staff interviews, the facility failed to ensure the call light system was functioning properly in its entirety. Specifically, the facility failed to ensure all 27 residents on the secure unit had access to a functioning call light system. Findings include: I. Facility policy The Call Light/Bell policy, revised May 2023, was provided by the director of nursing (DON) on 3/21/24 at 10:00 a.m. The policy revealed in pertinent part, It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: Answer the call light/bell within a reasonable time. Turn off the call light/bell. Listen to the resident's request/need. Respond to the request. If the item is not available or you are unable to assist, explain the resident and notify the charge nurse for further instructions. Leave the resident comfortable. Place the call device within the resident's reach before leaving the room. If the call light/bell is defective, immediately report this information to the unit supervisor. II. Facility layout and initial observations The secure unit consisted of two resident hallways that housed 27 residents and connected to a main hallway that contained the main entrance, common area and nurses station. On 3/19/24 at 11:15 a.m call lights in room [ROOM NUMBER] were observed: There was a call light button over a bed in room [ROOM NUMBER] and no call light in the bathroom of room [ROOM NUMBER]. Each resident room in the secure unit had a light over their door in the facility hallway. Two of the lights were painted over so the light was not visible under the paint. No lights were turned on over the resident's doors during the survey for the following dates and times: 3/17/24 from 3:00 p.m. to 6:00 p.m., 3/18/24 to 3/20/24 from 9:00 a.m. to 5:00 p.m, and 3/21/24 from 9:00 a.m. to 12:30 p.m. III. Resident #111 A. Resident status Resident #111, age 65, was initially admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), fracture of the fourth vertebrae, encephalopathy (change in brain function), epilepsy, high blood pressure, muscle weakness, history of traumatic brain injury and disorientation. The 1/2/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15 with no behaviors. The resident needed staff set-up assistance with bathing, dressing, using the toilet, and eating, and all transfers, including toileting and tub/shower. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview and observations Resident #111 was interviewed on 3/17/24 at 3:00 p.m. Resident #111 said the call light system above his bed and in his bathroom did not work and the call lights did not go anywhere. Resident #111 said he could push the button on the call light in the bathroom or pull the call light cord. The call light system was observed on 3/17/24 at 12:59 p.m. in Resident #111's room. The call light for the bed was non-functional. The call light for the bathroom activated inside the bathroom when pushed by showing a red light on the call button, but did not activate the light over Resident #111's door or activate a notification system at the nurses station. Resident #111's room was at the end of a hallway farthest from the nurses station and common area of the secure unit. An unidentified certified nurse aide (CNA) aide approached Resident #111's room at 3:07 p.m. The CNA said the staff performed 15 minute checks on the residents in the secure unit because the call light system was not used and did not work. -A review of Resident #111's electronic medical record revealed 15 minute checks were not documented or recorded in his electronic medical record. C. Record review Resident #111's care plan for activities of daily living (ADLs) for self-care performance deficit related to weakness, cognitive deficits, seizures and history of traumatic brain injury was initiated on 12/29/23. Pertinent interventions encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use the bell to call for assistance and that Resident #111 required the assistance of 1-2 staff members for transfers, bed mobility, toilet use and showers. -Resident #111's care plan did not encourage staff to ensure the resident's call light was functional or include a care plan or intervention for scheduled resident monitoring. The care plan failed to provide alternatives for Resident #111 since the call system did not function. IV. Staff interviews The maintenance supervisor (MS) was interviewed on 3/20/24 at 1:30 p.m. The MS said the call light system on the secure unit was not functional primarily because the residents were unable to use it. The MS was not sure how long or when the facility stopped using the call light system. The MS said the call light over the beds were part of the defunct call system and not in use, and the call light in Resident #111's bathroom was part of a wireless call light system used on the rehabilitation unit but the call light did not alert anywhere. Certified nurse aide (CNA) #1 was interviewed on 3/20/24 at 2:35 p.m. CNA #1 said she was not aware Resident #111 had a call light in his bathroom or that Resident #111 had an intervention on this care plan to encourage him to use a call light. The minimum data set (MDS) coordinator for the secure unit was interviewed on 3/20/24 at 2:40 p.m. She said the care plan intervention for Resident #111's call light encouragement was a standard intervention that was added to all residents' care plans in the secure unit. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staffing development coordinator (SDC) was interviewed on 3/20/24 at 2:41 p.m. The SDC said residents in the secure unit were evaluated upon admission for appropriate use of the call light but it was possible that not all of them were uploaded into the electronic medical record. Assistant director of nursing (ADON) #1 was interviewed on 3/21/24 at 10:30 a.m. ADON #1 said if Resident #111 fell in his bathroom, the staff on the secure unit would hear the fall and get to the resident timely so that Resident #111 would not have to wait until staff completed their 15 minute rounds to find him. V. Facility follow up The nursing home administrator (NHA) provided the Call Light/Bell Secured Unit Policy, revised October 2014, on 3/22/24 at 2:28 PM. The policy read in pertinent part, It is the policy of this facility to provide the resident a means of communication with nursing staff. Residents on the secure unit will be assumed to need to have their needs and wants anticipated by staff. Staff is selected to round on residents regularly to ensure all needs are met. Residents with moderate to severe cognitive impairment are unable to utilize a call light system appropriately. Further, resident with moderate to severe cognitive impairment are unable to be taught to use a call light system and presence of call lights in the room present risk related to entanglement, uniting the call light for harm to self or other and an infection control risk. If a resident is unable to use the call light, keep all cords out of the resident's reach to keep residents safe from getting tangled on the cord. Facility to provide frequent checks to anticipate resident needs due to the inability to use the call-light system and potential for injury by getting tangled in the call light cord. -However, Resident #111 had a call light with a pull cord in his bathroom and was able to explain the call light function. Staff were notified on 3/17/24 the call button in the bathroom was pushed and the call light remained in Resident #111's bathroom throughout the survey process. The facility provided two call light assessments for Resident #111 on 3/22/24. The assessments were completed on 12/28/23 and 3/21/24 (the last day of survey). The call light assessment documented the resident was unable to demonstrate how to use the call light button. -However, there was no additional documentation provided as to whether the call light with the attached cord remained in Resident #111's room or updates to Resident #111's care plan.