STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065183	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Progressive Care Center	1338 Phay Ave Canon City, CO 81212

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 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** 48114 Based on record review and interviews, the facility failed to take steps to prevent abuse for three (#40, #10 and #35) of three residents reviewed for abuse out of 29 sample residents. Specifically, the facility failed to protect Resident #40, Resident #10 and Resident #35 from physical abuse. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation Prevention policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 11/4/24 at 5:30 p.m. It read in pertinent part, Our facility prohibits the abuse, mistreatment, neglect, and/or exploitation of residents. We believe that all residents have the right to be free from such actions by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving our community, family members or legal guardians, friends, or any other individuals. The facility will train all employees, through orientation and on-going training sessions (online training and in-services) on issues related to abuse prohibition practices such as what constitutes abuse, neglect, and misappropriation of resident property. As part of our facility's attempt to prevent abuse, neglect, and/or exploitation of our residents, we will provide residents, families, and staff with information on how and to whom they may report concerns, incidents and grievances without fear of retribution; and provide feedback regarding to concerns that have been expressed. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. The individual conducting the investigation will, as a minimum; review the resident's medical record to determine events leading up to the incident. II. Incident of physical abuse involving Resident #10, Resident #40 and Resident #35 on 10/26/24 (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation was provided by the NHA on 11/5/24 at 3:30 p.m. The investigation, dated 10/27/24 at 1:15 p.m., documented the following information: Resident #10 said when CNA #1 was changing her bed and rolling her around, CNA #1 was jerking on the sheets. When CNA #1 was finished, Resident #10 said she asked for her pillow back. Resident #10 said CNA #1 hit her with his hand in her right ear while placing the pillow under her head. Resident #10 said she did not report the incident last night (10/26/24) and reported it the next day (10/27/24). Resident #10 was assessed and there was no redness to her ear and she was monitored for any latent bruising. (However, according to the 10/27/24 nursing progress note, the resident had redness to her right ear and right face - see record review below). Resident #10 said she was not afraid of CNA #1. Resident #10 was notified that CNA #1 was suspended pending investigation of the incidents. On 10/28/24 the NHA documented that during the investigation, another resident (Resident #40) alleged the same CNA (CNA #1) had pushed too hard when rolling her causing her to hit her hip on the wall. Resident #40 said CNA #1 had also yelled at her roommate, Resident #35. Resident #40 said CNA #1 was telling Resident #35 to get up and he needed to get Resident #35 changed. Resident #40 said after CNA #1 had gotten Resident #35 up, he left the room and left Resident #35 on the commode. Resident #40 said CNA #1 did not come back into the room and Resident #35 had to get herself changed and dressed. Resident #40 said she was not afraid of CNA #1 and said next time she saw CNA #1 she was going to kick him in the teeth. The police department was notified of the additional information and came to the facility to add to the report and speak with Resident #40. On 10/28/24 the NHA documented that she interviewed Resident #35. Resident #35 said her care was fine. The NHA asked if Resident #35 remembered CNA #1 providing care for her and Resident #35 said she remembered CNA #1. Resident #35 said CNA #1 was a very nice young man. Resident #35 said CNA #1 assisted her to the bedside commode. Resident #35 did not report any other issues. On 10/28/24 interviews were conducted with three other residents and four staff members. None of the additional residents or the staff members had any concerns regarding abuse. On 10/28/24 the NHA documented that she completed a phone interview with CNA #1. CNA #1 said 10/26/24 was his second time working at the facility. The NHA asked CNA #1 if there were any concerns he had with any of the residents. CNA #1 said he felt like his interaction with one of the residents was odd. CNA #1 said the lady three doors down on the left side of the room was saying snarky stuff all night. CNA #1 said the resident was asking him to joke around with her. CNA #1 said he did not say anything back to the resident. The investigation documented CNA #1 said the call light was on in the room about three doors down on the left side of the hall. CNA #1 said when he walked into the room, he asked Resident #40 (on the left side of the room) how he could help. CNA #1 said Resident #40 told him what the explicit do you think I need help for. CNA #1 said he was caught off guard by the comment, but asked Resident #40 what he could do for her. CNA #1 said Resident #40 requested to go to bed and he assisted her. CNA #1 said during the night he answered Resident #40's call light several times. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation documented that CNA #1 said at 4:00 a.m he answered the call light again for Resident #40. CNA #1 said Resident #40 said she needed to be changed. CNA #1 said he asked Resident #40 if she was able to move and she told CNA #1 that he had to roll her. CNA #1 said Resident #40 was incontinent of bladder. CNA #1 said Resident #40 never said ouch or indicated any type of pain. CNA #1 said Resident #40 did not hit the wall when he turned her. The inveestigation documented CNA #1 said after he was done changing Resident #40 he assisted her roommate, Resident #35. CNA #1 said Resident #35 started saying a prayer while he was assisting her. CNA #1 said he asked Resident #35 if he could help get her to the commode and get her changed. CNA #1 said he had to speak loudly to Resident #35 because she was hard of hearing. CNA #1 said Resident #35's roommate, Resident #40, started yelling and said can' t you see she is doing something. CNA #1 said he told Resident #40 that he was doing his rounds and needed to make sure everyone was clean and dry. CNA #1 said Resident #40 told him that he had an attitude. CNA #1 said when he was assisting Resident #35, Resident #40 would answer for Resident #35. The NHA asked CNA #1 about Resident #10. CNA #1 said when he entered Resident #10's room towards the beginning of his shift, he noticed that Resident #10 was soiled. CNA #1 said he assisted Resident #10 into her bed and changed her. The NHA asked CNA #1 if he had any further interactions with Resident #10 the rest of the night. CNA #1 said he checked on Resident #10 during his rounds and she was dry. CNA #1 said during the 4:00 a.m. rounds he asked Resident #10 if she needed to be changed. CNA #1 asked Resident #10 if he could check her.CNA #1 said he asked Resident #10 if she needed to go to the bathroom and the resident told him yes CNA #1 said Resident #10 was incontinent of bowel and bladder. CNA #1 said he assisted Resident #10 with getting her changed and completed a bed change for the resident. CNA #1 said Resident #10 asked for her pillow, but he let Resident #10 knew that he would need to get her a new pillow since her pillow was soiled. CNA #1 said when he was leaving the room, Resident #10 began yelling at him to give her pillow back. Resident #10 said she wanted her pillow now. CNA #1 said when he came back into the room he set the pillow by Resident #10's head and Resident #10 placed the pillow under her head herself. CNA #1 then told Resident #10 to have a great night. The investigation indicated CNA #1 was suspended pending investigation of the incidents. The conclusion of the internal investigation was unsubstantiated based on the facility's determination that there was no willful acts of physical abuse. -However, Resident #10 was assessed on 10/27/24 and the right side of her face and ear was red (see record review below). III. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included atrial fibrillation (abnormal heart rate), schizoaffective disorder, anxiety disorder and borderline personality disorder (interpersonal relationship instability and distorted sense of self). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff for assistance with toileting hygiene and lower body dressing. She required substantial/maximum assistance with upper body dressing, rolling left and right, sitting to lying and lying to sitting on the side of bed. B. Resident interview Resident #10 was interviewed on 11/4/24 at 2:22 p.m. Resident #10 said last Monday night a male agency CNA (CNA #1) made her feel scared. She said the CNA was rough and he did not want to change her but he did it anyway. She said when she asked for her pillow, CNA #1 purposely hit her ear with his hand while putting the pillow under her arm. She said she reported the incident to the NHA the next day and she called the police. She said the police had talked to her about the incident. She said CNA #1 was not allowed on the premises and had not been back. She said if something was wrong that she would tell someone about it. She said she did not feel afraid and felt safe at the facility. Resident #10 was interviewed again on 11/6/24 1:40 p.m. She said CNA #1 being abusive because of the way he handled her care. She said CNA #1 came into her room with an attitude and it was not accidental that he hit her ear on purpose. She said when he hit her ear she said, Ouch leave me alone and get out of here. She said she did not see CNA #1 for the rest of the night. Resident #10 said she would not be upset if CNA #1 came back to work at the facility as long as he did not go to her room. She said she would not want him to provide personal care for her. She said she would be fine if he worked down a different hallway. She said she felt comfortable knowing that the facility investigated the abuse right away and called the police. C. Record Review The care plan for mood/behavior, revised on 3/1/24, documented Resident #10 had a history of alteration in mood or exhibition of behavioral symptoms related to schizoaffective disorder. Resident #10 heard voices all the time, such as a group of boys singing. She had a recent increase with Haldol (an antipsychotic medication). She had accused her roommate of stealing her money. Interventions included administering medications as ordered, allowing the resident time to calm down and reapproaching her at a later time, sending the resident to psychological counseling as recommended by the physician, interacting in an empathetic and supportive manner, monitoring and documenting each behavioral event and offering psychosocial support as needed. The 10/27/24 progress note documented when the resident was first assessed, her ear and her face were red on the right side. Resident #10 denied pain to either area. Resident #10 was assessed in the afternoon (on 10/27/24) and all the redness had gone away. No other injury or discoloration was noted to her right ear. IV. Resident #40 A. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included chronic respiratory failure with hypoxia, anxiety disorder and adjustment disorder with depressed mood. The 8/20/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for assistance with toileting hygiene, upper and lower body dressing and putting on/taking off footwear. She required substantial/maximal assistance with rolling left and right, sitting to lying and lying to sitting on the side of the bed. B. Resident interview Resident #40 was interviewed on 11/5/24 at 9:24 a.m. Resident #40 said CNA #1 told her to roll to the wall. She said she told CNA #1 that she could not and that he needed to help her. She said CNA #1 grabbed her arm and put a bruise on her arm and then he grabbed her right hip and she banged her head on the wall. She said she did not hit the wall hard. She said CNA #1 had a hold of her bad hip and she told him not to move her bad hip because it hurt. She said CNA #1 ignored her and kept pushing on her bad hip. She said when CNA #1 did not listen to her, it made her mad. She said she did not want to say anything else to CNA #1 because he would have pushed harder on her hip. She said she told CNA #1 that he was not listening to her. She said she did not feel afraid. Resident #40 said she told the NHA on 10/28/24 about the abuse regarding CNA #1. C. Record review The care plan for mood/behavior revised 4/16/24, documented Resident #40 had a history for alteration in mood or exhibition of behavioral symptoms related to anxiety and depression. Interventions included administering medications as ordered;,allowing the resident time to calm down and reapproaching at a later time, continuing to remind the resident of the importance of utilizing the call light and asking for help with cares, evaluating the resident's need and referring to psychological counseling as recommended by physician, interacting in an empathetic and supportive manner, monitoring and documenting each behavioral event, offering one to one interactions as needed, and offering psychosocial support as needed. -Review of Resident #40's EMR revealed there were no progress notes related to the resident's physical abuse allegation with CNA #1 on 10/27/24. -Review of Resident #40's EMR revealed there was no documentation that indicated a skin assessment was completed related to Resident #40's allegation. V. Resident #35 A. Resident status Resident #35, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia and muscle weakness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/23/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 10 out of 15. She required substantial/maximal assistance with toileting hygiene and upper and lower body dressing She required partial/moderate assistance with toilet transferring. B. Record review The care plan for mood/behavior, revised 6/16/24, documented Resident #35 had a history of alteration in mood or exhibition of behavioral symptoms related to dementia. Resident #35 would often use her wash basin to urinate in during the night. Interventions included providing a bedside commode next to bed during the night, interacting in an empathetic and supportive manner, offering one to one interactions as needed and offering psychosocial support as needed. -Review of Resident #35's EMR revealed there were no progress notes related to the resident's physical abuse allegation with CNA #1 on 10/27/24. VI. Staff interviews CNA #2 was interviewed on 11/6/24 at 8:58 a.m. CNA #2 said when there was an allegation of abuse she would call the police and report it to the director of nursing (DON) and the NHA. CNA #2 said the nurse, the DON, or anybody could document that there was abuse reported. She said she did not have access to write a progress note in the resident's chart. CNA #2 said she did not hear about the abuse regarding CNA #1, Resident #10, Resident #40 and Resident #35. She said she had not seen any behavioral changes in Resident #10, Resident #40 and Resident #35 recently. CNA #2 said she received abuse training when she started working at the facility. She said she had not received any recent education or training on abuse. Licensed practical nurse (LPN) #1 was interviewed on 11/6/24 at 9:11 a.m. LPN #1 said when there was an allegation of abuse, she would notify the NHA. She said the NHA was responsible for documenting in the resident's chart regarding the abuse allegation. She said she was not working the night the allegation of abuse occurred with CNA #1. She said she heard about what had happened in the morning report on 10/30/24. She said she had not noticed any changes in Resident #10, Resident #40 or Resident #35's behavior recently. LPN #1 said Resident #10 was monitored for her ear after the incident on 10/26/24 and she had no visual signs of bruising on her ear. She said Resident #10 was on alert charting and monitoring for three days or until it resolved. She said there was no bruising noted to Resident #10 ear. The NHA was interviewed on 11/7/24 at 10:32 a.m. The NHA said she was the abuse investigator for the facility. She said she received a call from LPN #3 on 10/27/24 and said Resident #10 had reported to her that she had issues with CNA #1 last night (10/26/24). The NHA said Resident #10 reported that CNA #1 had hit her on her right ear. The NHA said LPN #3 told her that she had put in orders to monitor Resident #10's ear. The NHA said (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 told her a skin assessment was completed and no redness was reported. She said Resident #10 reported she was not afraid of CNA #1. The NHA said Resident #10 said she was alright and that she did not like CNA #1. The NHA said she talked to Resident #10 over the phone. The NHA said Resident #10 said CNA #1 had hit her in the ear with his left hand. The NHA said when she asked Resident #10 if it was an accident, the resident said no, that CNA #1 had hit her on purpose. The NHA said she told Resident #10 that she was sorry that it happened. The NHA said Resident #10 was asked if she reported the incident right away and Resident #10 said no, that she reported it the next day. The NHA said she told Resident #10 that CNA #1 was going to be suspended. The NHA said she added Resident #10 to alert charting and called the police. The NHA said the police went to the facility and interviewed Resident #10. The NHA said when she came in Monday morning (10/28/24) she started her investigation with the staff and the residents. The NHA said during her investigation, another resident (Resident #40) came forward about having problems with CNA #1. The NHA said Resident #40 reported she did not like CNA #1's demeanor and the way he spoke to her roommate, Resident #35. The NHA said Resident #40 told her to look at her arm and there was discoloration and a line on Resident #40's arm. She said Resident #40 said she had her call light on to be changed. The NHA said Resident #40 said CNA #1 came into her room to change her and when CNA #1 was rolling her on her side, he pushed so hard that she hit her hip on the wall. The NHA said Resident #40 told her about her roommate, Resident #35. The NHA said Resident #40 said CNA #1 was yelling at Resident #35 and telling her that she needed to get up. The NHA said Resident #40 said CNA #1 left Resident #35 on the commode and never came back to get her off. The NHA said Resident #40 said Resident #35 had to get herself off the commode and back into bed by herself. The NHA said she called the police again and asked if she needed to make a new report and the officer said no. The NHA said the same police officer came to the facility and met with Resident #40. The NHA said Resident #40 reported to the officer that she had hit her head while CNA #1 was changing her and not her hip. The NHA said she met with Resident #35 on 10/28/24. The NHA said Resident #35 had dementia and was forgetful. She said she asked Resident #35 if she remembered CNA #1 and she said he was a nice man. The NHA said Resident #35 said CNA #1 had helped to get her on the commode and she had no concerns about him. The NHA said she followed up with all three residents a few days later. She said none of the residents had any changes in their behaviors in regards to eating, sleeping and attending activities. She said she talked to the residents about CNA #1 coming back to work at the facility. She said Resident #10 said she did not care if he came back as long as he did not mess with her pillow. The NHA said Resident #40 said she was fine with him coming back as long as he was not taking care of her. The NHA said Resident #35 said she would not have any issues with CNA #1 coming back. The NHA said all three residents reported feeling safe and not afraid. The NHA said CNA #1 was an agency CNA. She said he had completed the abuse training before working at the facility. She said CNA #1 had not come back to work at the facility yet. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said she documented the investigation by typing up the abuse on the computer and placing the documentation in a file. She said she did not document the abuse incident in the chart. She said it was important for the nursing staff to know what was going on.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, record review and interviews, the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care for the resident that met professional standards of quality care for one (#110) of one resident out of 29 sample residents. Specifically, the facility failed to develop and implement within 48 hours of admission a person-centered baseline care plan for Resident #110 that included pertinent healthcare information, specifically related to the resident's hard cervical collar and fractured left wrist, necessary to properly care for the resident. Findings include: I. Facility policy and procedure The Baseline Care Plan policy, revised March 2022, was provided by the nursing home administrator (NHA) on 11/7/24 at 8:16 a.m. It read in pertinent part, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: -Initial goals based on admission orders and discussion with the resident/representative; -Physician orders; -Dietary orders; -Therapy services; -Social services; and, -PASARR (pre-admission screening and resident review program) recommendations, if applicable. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: -The stated goals and objectives of the resident; -A summary of the resident's medications and dietary instructions; -Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and, -Any updated information based on the details of the comprehensive care plan, as necessary. Provision of the summary to the resident and/or resident representative is documented in the medical record. II. Resident #110 A. Resident status Resident #110, age greater than 65, was admitted on [DATE] and discharged home per resident request on 11/6/24. According to the November 2024 computerized physician orders (CPO), diagnoses included displaced fracture of the first cervical vertebra (broken neck), nondisplaced fracture of lunate left wrist (broken wrist) and insomnia. The 11/5/24 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 functional status section of the assessment was not completed and was in progress at the time of the survey. B. Resident observation and interview On 11/4/24 at 12:37 p.m. Resident #110 was in bed with his left wrist/forearm in a cast and a hard cervical collar around his neck. Resident #110 said he had been admitted to the facility for rehabilitation. Resident #110 said he had not been informed by the facility when he would see his orthopedic doctor, get an x-ray/CT scan of his neck or wrist, when his neck brace could come off or when his left forearm/wrist brace would be removed. Resident #110 said he had received a shower that day from a certified nursing aide (CNA) and his hard cervical collar had been removed. III. Record review -Review of Resident #110's electronic medical record (EMR), as well as the resident's paper medical record, revealed no evidence that a baseline or comprehensive care plan had been developed to address the needs of the resident, specifically related to the resident's hard cervical collar and fractured left wrist. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note dated 11/3/24 documented Resident #110 required daily skilled nursing related to falls at home with a left wrist fracture and C1 (first cervical vertebra) fracture. He was working with physical therapy/occupational therapy (PT/OT) and was cooperative with care. The resident's left wrist had a splint in place and the resident was wearing a cervical collar. -Despite the nurse's progress note, the facility failed to implement a baseline care plan which addressed Resident #110's weight-bearing status of his left wrist, his need for PT/OT or if the resident's hard cervical collar could be removed for skin checks and showers. Cross-reference F684 for failure to ensure residents received treatment and care in accordance with professional standards of practice. IV. Staff interviews CNA #3 was interviewed on 11/6/24 at 8:55 a.m. CNA #3 said she began working with Resident #110 on 11/3/24. CNA #3 said the care plan was not loaded into the resident's EMR yet so she got Resident #110's care information/report from another CNA who said he had a neck and arm brace. CNA #3 said she gave Resident #110 a shower on 11/4/24 and the resident took off his neck brace and she wrapped his left arm splint so it would not get wet. CNA #3 said not having a baseline care plan put her in a bad position when she did not know important details about a resident. CNA #3 said she did what she could until she knew more about the resident. CNA #3 said the more she knew about a resident, the better care was provided because effective communication was crucial. CNA #3 said she received education on 11/5/24, during the survey, (see facility follow up below) that a new communication book, which included baseline care plans for the residents, was at the nurses station. CNA #3 said she thought the communication book would help make everyone more safe. CNA #3 said did not want to hurt a resident who was here for rehabilitation and the more knowledge she had helped with resident pain control when transferring and providing care. Registered nurse (RN) #1 was interviewed on 11/6/24 at 8:59 a.m. RN #1 said she worked in the rehabilitation hall. RN #1 said she had recently received education about the process for a new baseline care plan notebook (see facility follow up below). RN#1 said she loved the idea of the new baseline care plan book because it was a good quick glance reference for important resident care information. RN #1 said with high resident turnover, care changes with diagnoses and resident progress with therapy, it was good to have the communication binder and it gave her confidence to know what was going on with each resident. RN #1 said the rehabilitation residents were in and out quickly and there was a potential to get things mixed up with all the new residents. RN #1 said not knowing all the details about a resident could put her in a bad position when providing care. RN #1 said it was essential to have a baseline care plan day one because nurses needed to know important healthcare information about each resident. RN #1 said Resident #110 was alert and oriented and could tell the staff some things. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assistant director of nursing (ADON) and the NHA were interviewed together on 11/6/24 at 10:55 a.m. The ADON and the NHA said the facility had not developed baseline care plans for residents but had started developing them today (11/6/24) for all residents. The ADON and the NHA said nurses had previously conducted an admission/readmission evaluation assessment but the assessment did not trigger staff to create a baseline care plan for residents. The ADON said it was important to establish a baseline care plan for residents because it provided a person-centered care service plan for the CNAs to follow for each resident. She said a baseline care plan should provide the minimum healthcare information necessary to properly care for the immediate needs of each resident. The NHA said a baseline care plan was not created until today (11/6/24) for Resident #110. V. Facility follow up On 11/6/24 at 8:40 a.m. the NHA provided documentation via email that baseline care plans for all newly admitted residents were placed in a communication binder for staff to utilize. The newly created baseline care plan for Resident #110 revealed special instructions that the Resident was non-weight bearing on his left wrist and staff was to ensure the resident wore his hard cervical collar and the left wrist brace, but the collar and the wrist brace could be removed for showers and skin checks. The email further provided documentation of education that had been started with the staff on 11/5/24. The education revealed a communication binder would be made available to ensure new residents' needs were communicated to the staff. This would ensure continuity of care was maintained and resident safety measures were met. Information such as weight bearing status, diet, device status, such as braces and casts, including whether it could be removed should be included. Nurses were to familiarize themselves with the communication form and ensure that the information on the form was obtained when they were receiving report from a transferring facility. CNAs were to familiarize themselves with the communication binder, especially on their first day back to work after time off. The education included 23 staff members' signatures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to develop a comprehensive care plan for services that were provided in order to attain the resident's highest practicable physical, mental and psychological well-being and to provide effective and person-centered care for one (#40) of one resident out of 29 sample residents. Specifically, the facility failed to ensure Resident #40 had a care plan for the use of an anticoagulant medication. Findings include: I. Resident #40 A. Resident status Resident #40, age 75, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included chronic respiratory failure with hypoxia, atrial fibrillation (irregular heartbeat) and anxiety disorder. The 8/20/24 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. She was dependent on staff assistance with toileting hygiene, upper and lower body dressing and putting on/taking off footwear. The assessment indicated the resident received an anticoagulant medication daily. B. Record review The November 2024 CPO revealed the resident had a physician's order for Xarelto (a blood thinner) 15 mg (milligrams), give one tablet by mouth one time a day for atrial fibrillation, ordered on 5/15/24. -A review of the comprehensive care plan did not reveal a care plan addressing the use of the anticoagulant medication or its side effects. C. Staff interviews The assistant director of nursing (ADON) was interviewed on 11/7/24 at 11:07 a.m. The ADON said if a resident was taking an anticoagulant they should be monitored on every shift for any complications. He said residents who were prescribed an anticoagulant should have a care plan. He said he was responsible for making sure that a care plan was in place. He said he coordinated changes and educated the nurses on any changes made on the plan of care. He said when the order came in for the anticoagulant medication that he missed it.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, record review and interviews, the facility failed to ensure one (#110) of one resident out of 29 sample residents received treatment and care in accordance with professional standards of practice. Specifically, for Resident #110, the facility failed to: -Obtain physician's orders which indicated if it was acceptable to remove the resident's hard cervical (neck) collar brace for skin checks and showers; -Obtain physician's orders for the weight bearing status of the resident's fractured left wrist; -Follow up on scheduling the resident's neurosurgeon/orthopedic doctor's appointment and CT (computed tomography) scan appointment; and, -Ensure nursing staff were aware of and informed of pertinent healthcare information related to the resident's hard cervical collar and fractured left wrist. Findings include: I. Resident #110 A. Resident status Resident #110, age greater than 65, was admitted on [DATE] and discharged home per resident request on 11/6/24. According to the November 2024 computerized physician orders (CPO), diagnoses included displaced fracture of the first cervical vertebra (broken neck), nondisplaced fracture of lunate left wrist (broken wrist) and insomnia. The 11/5/24 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 functional status section of the assessment was not completed and was in progress at the time of the survey. B. Resident interview and observation On 11/4/24 at 12:37 p.m. Resident #110 was in bed with his left wrist/forearm in a cast and a hard cervical collar around his neck. Resident #110 said he had been admitted to the facility for rehabilitation. Resident #110 said he had not been informed by the facility when he would see his orthopedic doctor, get an x-ray/CT scan of his neck or wrist, when his neck brace could come off or when his left forearm/wrist brace would be removed. Resident #110 said he had received a shower that day from a certified nursing aide (CNA) and his hard cervical collar had been removed. C. Record review (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #110's 10/15/24 hospital discharge summary and instructions revealed Resident #110 was to follow up with his primary care physician (PCP), neurosurgeon and orthopedic surgeon. The summary revealed the resident's active issues requiring follow up included: -Following up in the neurosurgery clinic in two weeks for a repeat cervical spine CT; and, -Following up with an orthopedic surgeon for the left lunate (wrist) fracture. The summary included the names, addresses and phone numbers for the physicians the resident was to follow up with. A review of a 10/28/24 community PCP visit note revealed Resident #110 was seen for a follow-up appointment following a recent hospital stay. The PCP's note revealed the resident's wife was having difficulties managing the resident's care at home and the resident and his wife agreed to a short-term rehabilitation stay at a skilled nursing facility. Review of the facility's electronic medical record (EMR), as well as the paper medical record, for Resident #110 revealed no evidence that a baseline or comprehensive care plan had been developed upon the resident's admission to the facility on [DATE] to address the needs of the resident, specifically related to the resident's hard cervical collar and fractured left wrist. A nurse progress note dated 11/3/24 documented Resident #110 required daily skilled nursing related to falls at home with a left wrist fracture and C1 (first cervical vertebra) fracture. He was working with physical therapy/occupational therapy (PT/OT) and was cooperative with care. The resident's left wrist had a splint in place and the resident was wearing a cervical collar. -Despite the nurse's progress note, the facility failed to implement a baseline care plan which addressed Resident #110's weight-bearing status of his left wrist, his need for PT/OT or if the resident's hard cervical collar could be removed for skin checks and showers. Cross-reference F655 for failure to develop and implement a baseline care plan within 48 hours of admission in order to provide the minimum healthcare information necessary to properly care for the immediate needs of the resident. Review of Resident #110's November 2024 CPO revealed a physician's order to monitor the skin around the resident's neck brace daily, ordered 11/4/24. -There was no physician's order which indicated if the resident's hard cervical collar could be removed for skin checks or showers. -There was no physician's order for the weight bearing status of the resident's left wrist. The 11/4/24 OT start of care evaluation revealed precautions/contraindications documented by the OT included a non-weight bearing status for Resident #110's left upper extremity. The 11/4/24 PT start of care evaluation revealed precautions/contraindications documented by the PT included the resident was to wear the neck brace at all times and possible weight bearing precautions for the left wrist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/4/24 facility physician's progress note revealed Resident #110 was in the hospital from 10/6/24 to 10/15/24 related to a mechanical fall from standing and the resident had the following injuries: a minimally displaced bilateral anterior and left posterior C1 arch fracture without atlantoaxial/subluxation and a closed non-displaced left lunate fracture. The note documented the hospital neurosurgeon recommended non-operative management of the C1 fracture with a cervical collar and the hospital's orthopedist recommended non-operative management of the left lunate (wrist) fracture with a splint. The resident underwent surgery for a right occipital hematoma which was performed without complication. -However the physician's note did not reveal the recommended weight bearing status of the resident's left wrist or if the cervical collar and the wrist splint could be removed for showers or skin checks. -Review of Resident #110's EMR revealed there were no follow up neurosurgeon/orthopedic doctor's appointments scheduled or follow up CT scan appointments. A nurse progress note dated 11/4/24 documented that Resident #110 had received a shower in the morning. According to the resident's interview on 11/4/24, the CNA removed his cervical collar during the shower on 11/4/24 (see resident interview above). II. Staff interviews The nursing home administrator (NHA) and the director of nursing (DON) were interviewed on 11/5/24 at 4:19 p.m. The NHA and the DON said there was no care plan documented in Resident #110's EMR because the resident had just been admitted to the facility on [DATE]. The NHA and the DON said they completed baseline care plans by day five after a resident's admission. The NHA and the DON said staff communicated verbally to relay important information about a resident's specific care needs until a care plan was developed. The NHA and the DON said they needed to find out when Resident #110 would see his orthopedic doctor and then they could find out when his cervical collar was scheduled to come off. The NHA and the DON said they would follow up in regards to whether or not the resident's cervical collar could be removed for bathing. The NHA and the DON said Resident #110 had a platform walker and was non-weight bearing on his left upper extremity (LUE). The NHA and the DON said since there was no care plan in place, the CNAs knew about the weight-bearing status from a verbal report, however, they said a verbal report was not the most comprehensive way to let the CNAs know about residents' pertinent healthcare information. The NHA and the DON said the residents' care information would usually be included in the CNA tasks in the EMR after the care plan was developed, however, they said the weight bearing status for Resident #110's LUE was not documented in the EMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and the DON said they planned to develop a new communication binder that would include a baseline care plan, a communication white board and a temporary individual care service plan for the CNAs to utilize for resident care. The NHA and the DON said they planned to complete a whole house audit to determine any resident limitations, how to transfer, and educate staff on the new communication book until the white boards had arrived. III. Facility follow up On 11/5/24 at 6:22 p.m. the NHA sent an which indicated Resident #110 had been scheduled for an orthopedic appointment and a CT scan. The email further revealed physician's orders had been obtained which indicated the resident could remove his cervical collar during showers or baths. On 11/6/24 at 8:40 a.m. the NHA provided the following documentation via email: Copies of communication sheets that the facility would be using until the ordered white communication boards. A copy of education that had been started with the staff on 11/5/24. The education revealed a communication binder would be made available to ensure new residents' needs were communicated to the staff. This would ensure continuity of care was maintained and resident safety measures were met. Information such as weight bearing status, diet, device status, such as braces and casts, including whether it could be removed should be included. Nurses were to familiarize themselves with the communication form and ensure that the information on the form was obtained when they were receiving report from a transferring facility. CNAs were to familiarize themselves with the communication binder, especially on their first day back to work after time off. The education included 23 staff members' signatures. The documentation provided by the NHA additionally revealed baseline care plans for all newly admitted residents was placed in a communication binder for staff to utilize. The newly created baseline care plan for Resident #110 revealed special instructions that the Resident was non-weight bearing on his left wrist and staff was to ensure the resident wore his hard cervical collar and the left wrist brace, but the collar and the wrist brace could be removed for showers and skin checks. The email further indicated the following physician's orders were obtained on 11/6/24: -Okay to remove cervical collar during showers or baths; -Okay to remove wrist splint in the shower or bath. NWB to left wrist; and, -Resident has follow-up appointment with orthopedic surgeon and CT scan on 11/21/24.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to ensure residents received the proper treatment and assistive devices to maintain hearing and vision for two (#7 and #40) of two out of 29 sample residents. Specifically, the facility failed to: -Ensure Resident #7 received hearing aids and vision services in timely; and, -Ensure Resident #40 received timely vision services. Findings include: I. Facility policy and procedure The Ancillary Services policy and procedure, revised October 2023, was provided by the nursing home administrator (NHA) on 11/7/24 at 8:13 a.m. It read in pertinent part, Residents shall have access to annual vision screenings conducted by qualified professionals. Eyeglasses and corrective devices will be provided in accordance with individual care plans. The facility will provide support for the purchase and maintenance of hearing aids as per the resident needs. A designated staff member (social services director or designee) will oversee coordination of all ancillary services. Documentation of all referrals, services rendered, and follow ups must be maintained in the residents ' health records. II. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included glaucoma (high eye pressure) and dementia. The 9/25/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. She required supervision with toileting and transfers She required set up assistance with eating, personal hygiene and was independent with bed mobility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident had moderate hearing difficulty and wore hearing aids. It indicated the resident had adequate vision and did not wear corrective lenses or glasses. B. Observations and resident interview On 11/4/24 at 2:37 p.m. Resident #7 was sitting in bed with the television on loud. She was not wearing hearing aids and was wearing glasses. Resident #7 said her current hearing aid ear pieces were not the right size and the staff was trying to figure out on getting her a size that would stay in her ear. She said she had great difficulty hearing without hearing aids and people had to speak very loudly to her. She said she was due to see an eye doctor and she needed new glasses. She said her current glasses made it difficult for her to see her television. She said she did not know when or if an appointment was set up for the eye doctor. C. Record review The hearing care plan, initiated on 12/28/18 and revised on 7/31/24, indicated Resident #7 had a hearing deficit and new hearing aids were being ordered and were in the PETI process (post eligibility of treatment income submission request). Interventions included allowing time to respond, repeat as necessary when speaking, turn off the television/radio to reduce environmental noise, wearing headphones when watching television and referring to an audiologist as needed. The vision care plan, initiated on 12/30/18 and revised on 3/23/23, indicated Resident #7 had the potential for visual impairment due to glaucoma and dry eye syndrome. Interventions included arranging visits to the eye doctor, encouraging her to wear her eyeglasses, providing large print, keeping the environment free of clutter and reporting missing/broken glasses to the social service director (SSD). The 5/9/24 care conference summary progress note documented Resident #7 wore glasses and wanted new glasses. It documented that she wore hearing aids and needed to be seen by an audiologist. The 6/12/24 state medical assistance program response to PETI requested benefits for hearing aids documented it was approved. The 6/21/24 email documented from the business office manager (BOM) to the accounts receivable director (ARD) indicated that PETI approval was received for the hearing aids. The 6/21/24 email documented from the ARD to the BOM receipt of notification of approval and requesting further supporting documentation. The 7/18/24 care conference summary progress notes documented Resident #7 wore glasses and requested to get her eyes checked. It documented the SSD would schedule an appointment with vision. It documented Resident #7 was seen by audiology on 5/28/24 and new hearing aids were being ordered through the PETI process. -However, Resident #7 had not received new hearing aids or been seen by the eye doctor. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/17/24 care conference summary progress notes documented Resident #7 was seen by audiology on 5/28/24. It documented she wore glasses and was on the list to be seen. -However, Resident #7 had not received new hearing aids or been seen by the eye doctor. A comprehensive review of the electronic medical record (EMR) failed to reveal any further documentation of hearing aids being ordered or received. It failed to reveal a vision appointment for Resident #7. D. Staff interviews The NHA and the BOM were interviewed together on 11/6/24 at 10:00 a.m. The NHA said audiology, vision, podiatry and the dentist were all reviewed in the resident's care conference. She said the SSD was in charge and led the care conferences. She said currently the SSD was on leave. The BOM said PETI was the Medicaid process which can be applied for on line through the state portal for residents who needed new hearing aids . She said they were still waiting on the approval process for Resident #7. She said in the meantime they had gotten an amplifier for Resident #7 with the smaller ear buds but they were still too large for her ears. She said she was in the process of trying to find ear buds that would fit. The NHA said she was only able to find documentation that Resident #7 was on the list to be seen by vision services for the evaluation of new glasses. She said she could not find documentation if a vision appointment was made or when vision was coming in to see Resident #7. The BOM was interviewed on 11/6/24 at 10:22 a.m. The BOM said she found email documentation of the PETI approval for Resident #7 for her hearing aides that was dated on 6/12/24. She said she found an email she had sent to the ARD, dated 6/21/24, notifying her that the facility had received the PETI approval. She said she then received an email from the ARD that requested additional supporting documentation. She said she did not have any further documentation of follow up in the ordering or receiving of the hearing aids. She said she would submit the approval letter and the supporting documentation on 11/6/24. 48114 III. Resident #40 A. Resident status Resident #40, age 75, was admitted on [DATE]. According to the November 2024 CPO, the diagnoses included chronic respiratory failure with hypoxia, anxiety disorder and adjustment disorder with depressed mood. The 8/20/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent on staff for assistance with toileting hygiene, upper and lower body dressing and putting on/taking off footwear. The MDS assessment documented she had corrective lenses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #40 was interviewed on 11/4/24 at 3:12 p.m. Resident #40 said she had mentioned to a couple of staff that she needed to see someone to get her eyes checked. She said she would like to be seen by the eye doctor because her glasses broke. She said she had worn glasses for years. She said she had not seen the eye doctor since she was admitted to the facility in January 2024. C. Record review The vision care plan, revised on 8/26/24, documented Resident #40 had visual impairment and poor vision. She wore reading glasses at times. Interventions included adapting the environment to the resident's needs to ensure she was able to recognize objects/environment, arranging for visits to eye doctor as needed, ensuring the call light was within reach, ensuring that appropriate visual aids were provided to meet the residents needs, keeping the environment free of clutter, orienting the resident to her surroundings as needed and providing large print reading material, if applicable. The 7/23/24 care conference note documented theSSD would schedule vision appointment. The 10/24/24 care conference note documented the SSD was to schedule an appointment with optometry. The resident had glasses but they were broken prior to admission. The November 2024 CPO revealed a physician's order, may refer to ancillary services as needed for audiologist, dentist, dermatology, ophthalmology and podiatrist ordered on 1/23/24. -Review of Resident #40's EMR did not reveal the resident had been seen by the eye doctor. D. Staff interviews The BOM was interviewed on 11/6/24 at 2:00 p.m. The BOM said the social worker was responsible for arranging ancillary appointments for the residents. She said the social worker was out and she was covering for her while she was out. She said she was figuring out which residents needed services. She said the facility had ancillary services that came to the facility to see the residents. She said the residents were given the option to see someone outside the facility or to be seen at the facility. The BOM said she was not sure if Resident #40 wore glasses. She said Resident #40 had a care conference last week. She said Resident #40 told the staff about her broken glasses prior to admission. She said she would make sure that Resident #40 was on the list to be seen by the eye doctor. The BOM said that the resident should have been seen by the eye doctor sooner. She said it has been too long for her not to have been seen. She said she was putting a process in place so that the residents were seen by ancillary services sooner. She said the residents were asked if they would like ancillary services in their first care conference. The NHA was interviewed on 11/6/24 at 2:25 p.m. The NHA said social services was responsible for tracking ancillary appointments. She said the eye doctor came to the facility every other month. She said if the residents needed to be sooner that the facility offered for them to be seen elsewhere. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said in the initial care conference that was held within 48 hours, the residents should be asked if they were having issues or needed to be seen for ancillary services. She said those services should be set up right away especially if the resident was requesting to be seen. The NHA said Resident #40 should have been seen by the eye doctor sooner. She said if residents were having issues that they should be seen immediately. She said residents who requested services should be seen within the first 30 days of admission. She said the eye doctor had not been coming in regularly to see the residents. She said she would call them and arrange for Resident #40 to be seen.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and staff interviews, the facility failed to act upon recommendations by the pharmacist in a timely manner for one (#29) of five residents out of 29 sample residents. Specifically, the facility failed to ensure the pharmacist's monthly medication regimen review (MRR) recommendations and the associated physician's orders to discontinue baclofen and guaifenesin for Resident #8 were followed up on in a timely manner, which resulted in the resident receiving additional doses of the medications. Findings include: I. Facility policy and procedure The Medication Regimen Reviews policy and procedure, revised May 2024, was provided by the nursing home administrator (NHA) on 11/7/24 at 8:19 a.m. It read in pertinent part, The goal of the medication regimen review (MRR) is to promote positive outcomes while minimizing adverse consequences and potential risk associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice, is not supported by medical evidence, and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences. II. Resident #8 A. Resident status Resident #8, age 79, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included right humeral (upper arm bone) fracture, bipolar disorder and chronic pain. The 8/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial/maximal assistance with toileting, personal hygiene, bed mobility and transfers and set up assistance with eating. B. Record Review 1. Baclofen (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The November 2024 CPO revealed Resident #8 had a physician's order for baclofen (a muscle relaxant medication) 10 milligrams (mg) tablet every eight hours as needed for spasms, ordered 8/16/23. Review of Resident #8's June 2024 MRR revealed the following recommendations from the pharmacist: Baclofen 10 mg. The MRR documented the medication had not been administered to the resident since 4/17/24. The pharmacist's recommendation was to discontinue the medication. The physician responded to the recommendation with an order to discontinue the medication and the order was signed by the physician on 6/28/24. -The June 2024 medication administration record (MAR) documented baclofen 10 mg was administered to Resident #8 on 6/30/24. The July 2024 MAR documented baclofen 10 mg was administered to the resident on 7/1/24, 7/2/24, 7/7/24, 7/8/24, 7/16/24, 7/23/24, 7/30/24 and 7/31/24. The August 2024 MAR documented baclofen 10 mg was administered to the resident on 8/4/24, 8/5/24, 8/11/24, 8/12/24 and 8/27/24. The September 2024 MAR documented baclofen 10 mg was administered to the resident on 9/5/24, 9/7/24, 9/22/24 and 9/29/24. The October 2024 MAR documented baclofen 10 mg was administered to the resident on 10/13/24. A second review of Resident #8's November 2024 CPO revealed a physician's order to discontinue baclofen 10 mg every 8 hours as needed on 11/6/24, during the survey. There were no documented administrations of baclofen in the MAR for November 2024. -Resident #8 received 19 additional doses of baclofen due to the facility's failure to discontinue the medication until more than four months after the pharmacist recommended the discontinuation and the physician signed an order to discontinue the medication on 6/28/24. 2. Guaifenesin The November 2024 CPO revealed Resident #8 had a physician's order for guaifenesin 600 mg every 12 hours as needed for prophylaxis cold symptoms, ordered 4/18/23. Review of Resident #8's September 2024 MRR revealed the following recommendations from the pharmacist: Guaifenesin 600 mg as needed. The MRR documented the medication had not been administered to the resident since 8/5/24. The pharmacist's recommendation was to discontinue the medication. The physician responded to the recommendation with an order to discontinue the medication and the order was signed by the physician on 9/27/24. The October 2024 MAR documented guaifenesin 600 mg was administered on 10/6/24, 10/7/24, 10/9/24 and 10/11/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second review of Resident #8's November 2024 CPO revealed a physician's to discontinue guaifenesin 600 mg every 12 hours as needed for prophylaxis cold symptoms on 11/6/24, during the survey. There were no documented administrations of guaifenesin in the MAR for November 2024. -Resident #8 received four additional doses of guaifenesin due to the facility's failure to discontinue the medication until more than one month after the pharmacist recommended the discontinuation and the physician signed an order to discontinue the medication on 9/27/24. III. Staff interviews The director of nursing (DON) was interviewed on 11/7/24 at 11:15 a.m. The DON said the assistant director of nursing (ADON) would receive an email from the pharmacy with the pharmacist's recommendations for residents' medications. The DON said the recommendations were reviewed and shared with the physician for review and the physician's signature, if needed She said if the pharmacist's recommendations were accepted, the MRR was turned back into the ADON or the DON and the appropriate changes were made to the residents' medical records. The ADON was interviewed on 11/7/24 at 11:35 a.m. The ADON said there was a nurse who was working light duty and had been assisting with the MRR's and pharmacy recommendations. He said the pharmacy recommendations were missed during the time period the nurse was helping. He said the usual check and balances was if the pharmacy did not get a response back from the physician, they would send out another email to the facility regarding the previous recommendations. However, he said the facility did not receive another email from the pharmacy regarding Resident #8's medication recommendations. He said the physician's order to discontinue Resident #8's baclofen and guaifenesin was discovered during survey after the facility pulled the pharmacist's MRRs for the previous six months. The ADON said the medications were discontinued on 11/6/24, during the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection in two of three units. Specifically, the facility failed to: -Ensure resident rooms were cleaned in a sanitary manner; -Ensure manufacturer recommended surface contact times were followed for effective disinfection; and, -Ensure glucometers were cleaned in a sanitary manner. Findings include: I. Failure to clean and sanitize resident rooms appropriately A. Professional reference Centers for Disease Control (CDC). Environment Cleaning Procedures (3/19/24), was retrieved on 11/12/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Clean patient areas (patient zones) before patient toilets. Proceed in a systematic manner to avoid missing areas. In a multi bed area, clean each patient zone in the same manner. Mop from cleaner to dirtier areas. B. Manufacturer's recommendations According to the Bright Solutions HP202 (hydrogen peroxide) manufacturer guidelines, reviewed 2024, retrieved on 11/12/24 from https://mybrightsolutions.com/wp-content/uploads/046200BSL_Lit.pdf, For Use as a One Step Cleaner/Disinfectant. Spraysix to eight inches from the surface, making sure to wet surfaces thoroughly. All surfaces must remain visibly wet for 10 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For use as a Virucide. All surfaces must remain visibly wet for five minutes. A one minute contact time is required for HIV (human immunodeficiency virus, the virus that causes AIDS), Influenza Virus type A, SARS Coronavirus 2 (the virus that causes COVID-19). According to the Clorox Clean Up Disinfectant with Bleach manufacturer guidelines, reviewed 2024, retrieved on 11/12/24 from https://www.cloroxpro.com/products/clorox/clean-up-disinfectant, Spray four to six inches from the surface until thoroughly wet. Let stand 30 seconds or longer. Wipe with a wet sponge or cloth and rinse with water. For use as a Bactericidal the spray kill time is 30 seconds, for Escherichia coli (E. coli) 0157:H7 and ESBL (extended spectrum beta lactamase) producing E. coli a spray kill time of five minutes. For use as a Virucide (chemical that kills viruses) the spray kill time is 30 seconds, for Norovirus and Poliovirus a spray kill time of one minute. C. Facility policy and procedure The Cleaning and Disinfecting Resident's Rooms policy and procedure, revised August 2013, was provided by the housekeeping supervisor (HSKS) on 11/7/24 at 11:00 a.m. It read in pertinent part, Manufacturer's instructions will be followed for proper use of disinfecting (or detergent) products including: Recommended use-dilutions; Material compatibility; Stotowele; Shelf life; and, Safe use and disposal. Use heavy duty gloves (and other personal protective equipment as indicated) for housekeeping tasks. Perform hand hygiene after removing gloves. D. Observations On 11/7/24 at 8:55 a.m. housekeeper (HSK) #1 was cleaning room [ROOM NUMBER], where two residents resided. HSK #1 put on a glove on her right hand and obtained a saturated towel from the HP202 solution on the housekeeping cart. She started on the A side of the room and wiped the top of the bedside table, top of the overhead light, top of headboard and footboard. She then wiped the table at the foot of the bed. She then wiped the windowsill on the A side of the room. She then disposed of the used towel and removed the glove off her right hand. -HSK #1 failed to wear gloves on both hands during cleaning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Without performing hand hygiene, HSK #1 put on a new glove on her right hand, obtained a new saturated towel and the bottle of Clorox Clean Up disinfectant from the housekeeping cart. She then wiped down the overhead light and bedside table with the saturated towel on the B side of the room. She then spot cleaned a small area with the Clorox bleach and immediately wiped off with the same saturated towel. She then wiped the chair, bedside table, head and footboard of the bed. She then wiped the window sill on the B side of the room. She then disposed of the towel. Without performing hand hygiene HSK #1 placed a new glove on her right hand and obtained a new saturated towel from the housekeeping cart. She wiped the top of the towel dispenser, the top of the mirror and then the top of the vanity. She then wiped down the handrails on the bathroom walls, wiped the toilet handle, sprayed the top of the toilet seat and toilet bowl with the Clorox Clean Up. She then flushed the toilet. She then set the Clorox bottle on the floor of the bathroom. She then immediately wiped down the top of the toilet seat. She leaned on the top of the toilet bowl with her ungloved hand and wiped the top of the toilet bowl. She then proceeded down the sides of the toilet bowl. She then picked up the Clorox spray bottle with ungloved hand and returned to the housekeeping cart. She then disposed of the towel and glove. -HSK #1 failed to perform hand hygiene between tasks and changing gloves. She failed to wear gloves on both hands. She failed to perform hand hygiene after touching a contaminated surface (toilet) and touching clean items (Clorox spray bottle and housekeeping cart). -HSK #1 failed to clean the inside of the toilet bowl. -HSK #1 failed to ensure the bottle of disinfectant/cleaning solution was kept sanitary by keeping it off the floor in the bathroom. HSK #1 without performing hand hygiene obtained a reusable mop head soaking in disinfectant solution on the housekeeping cart. She started on the A side of the room, continued to the B side of the room and continued mopping the bathroom and then through the vanity to the room door. -HSK #1 failed to use separate mop heads for each side of the residents ' joint room and a separate mop head for the bathroom. -HSK #1 failed to ensure the surfaces for HP202 remained visibly wet for the five minute virucidal time and the ten minute total disinfection time and failed to ensure for Clorox remained visibly wet for the one minute virucidal time and the five minute total disinfection time specified by the manufacturer's guidelines (see guidelines above). On 11/7/24 at 9:10 a.m. HSK #1 was observed cleaning room [ROOM NUMBER]. HSK #1 performed hand hygiene and put on a pair of gloves . She obtained a saturated towel from the solution on the housekeeping cart. She sprayed the bedside table with Clorox spray and immediately wiped it down with the towel. She then wiped down overhead lights, bed head and footboard and windowsill. She then disposed of the towel and her gloves. Without performing hand hygiene she put on new gloves, obtained a new towel and wiped vanity lights, sink fixtures, vanity top and inside of the sink. She then disposed of the towel and gloves. Without performing hand hygiene she obtained a fresh mophead from the housekeeping cart and mopped the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HSK #1 failed to perform hand hygiene after removing her gloves. -HSK #1 failed to ensure the surfaces for HP202 remained visibly wet for the five minute virucidal time and the ten minute total disinfection time; and failed to ensure for Clorox remained visibly wet for the one minute virucidal time and the five minute total disinfection time specified by the manufacturer's guidelines (see guidelines above). E. Staff interviews HSK #1 was interviewed on 11/7/24 at 9:30 a.m. HSK #1 said the facility used HP202 (hydrogen peroxide) in the solution for the cleaning towels. She said the disinfection time was ten minutes. She said the Clorox Clean Up disinfection time was either one minute or three minutes but was not sure. She said she should be wearing both gloves while cleaning a room and performing hand hygiene after gloves were removed. She said she should have been wearing gloves while cleaning the toilet and she should not have stored the spray bottle on the floor of the bathroom because it was a dirty area. HSK #1 said she wore only one glove because she was told not to wear gloves out in the hallway. She said when the residents shared a room, each side of the room was cleaned separately. She said when she cleaned a room she started with the high areas before cleaning the lower areas because the lower areas were considered dirty. She said she was taught to mop a room using one mop head and starting from the far side of the room and mopping the bathroom last. The HSKS supervisor was interviewed on 11/7/24 at 10:00 a.m. The HSKS said a shared room should be cleaned like two separate rooms. She said gloves and hand hygiene should be performed after cleaning each side and each side should be mopped separately using a new mop head. She said the bathroom should be mopped last using a new mop head. She said the HP202 had a disinfection time of ten minutes and the Clorox Clean Up with bleach had a disinfection time of three minutes. She said when cleaning a toilet gloves should be used. She said gloves should be changed and hand hygiene performed after cleaning the toilet and touching any clean items. She said the inside of the toilet bowl should also be cleaned. She said she would follow up with the housekeepers regarding the procedure for cleaning rooms, disinfectant time of the chemical used in the cleaning process, and changing gloves and performing hand hygiene after touching a dirty area and before proceeding to a clean area. II. Failure to clean glucometers appropriately A. Professional reference The Centers for Disease Control and Prevention (CDC). Considerations for Blood Glucose Monitoring and Insulin Administration (2024), was retrieved on 11/12/24 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Unsafe%20practices%20during%20assisted%20monitoring,for%20more%20than%20one%20person. It read in pertinent part, Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. B. Manufacturer guidelines (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the [NAME] True Metrix manufacturer guidelines, undated retrieved on 11/12/24 from https://imgcdn.[NAME].com/CumulusWeb/Click_and_learn/True_Metrix_Manual.pdf. It read in pertinent part, To clean and disinfect the meter: Wash hands thoroughly with soap and water; To Clean make sure the meter is off and a test strip is not inserted. With only PDI Super Sani Cloth Wipes (EPA reg no. 9480-4), rub the entire outside of the meter using three circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter; To disinfect using fresh wipes, make sure that all outside surfaces of the meter remain wet for two minutes. The PDI Super Sani Cloth disinfecting wipes manufacturer guidelines (2024), were retrieved on 11/12/24 from https://pdihc.com/in-service/super-sani-cloth-disinfecting-wipes/. It included the following recommendations in pertinent part, Bactericidal, Tuberculocidal and Virucidal, effective for 30 microorganisms with a contact time of two minutes. The Metrex CaviWipes manufacturer guidelines, reviewed 2024, retrieved on 11/12/24 from https://www.metrex.com/en-us/caviwipes#kill. It read in pertinent part, Two minute efficacy against multidrug resistant bacteria MRSA (methicillin resistant staphylococcus aureus), VRE (Vancomycin resistant Enterococcus faecalis), HBV (hepatitis B), HCV (hepatitis C), human immunodeficiency virus (HIV); Three minute efficacy against Mycobacterium tuberculosis, Pseudomonas aeruginosa, Salmonella, Staphylococcus aureus. C. Observations On 11/16/24 at 7:37 a.m. licensed practical nurse (LPN) #1 was wiping a glucometer with an alcohol prep pad (used to disinfect skin prior to an injection) and returning it to its case in the medication cart that was labeled with an unidentified resident's name. -However, according to the manufacturer guidelines LPN #1 should have used the Super Sani Cloth Wipes and allowed the glucometer to remain wet for two minutes. She was then observed removing Resident #17's labeled glucometer to check her morning glucose. She took the glucometer to the resident's room and completed the blood glucose check. She then returned to the medication cart, disposed of the test strip and lancet in the biohazard container. She then wiped down the glucometer with an alcohol prep pad and returned it to its labeled case. -However, according to the manufacturer guidelines LPN #1 should have used the Super Sani Cloth Wipes and allowed the glucometer to remain wet for two minutes. D. Staff interviews LPN #2 was interviewed on 11/6/24 at 8:53 a.m. LPN #2 said each resident that needed blood glucose checks had their own designated glucometers. She said she used alcohol prep wipes to clean glucometers between uses. She said she was not aware of the manufacturer's recommendations on how to clean blood glucometers. She said the glucometers should be cleaned after every use because of blood borne pathogens. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065183	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Progressive Care Center	1338 Phay Ave Canon City, CO 81212

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 11/6/24 at 8:55 a.m. LPN #1 said all residents had their own dedicated glucometers and she would clean them with an alcohol wipe after each use. She said she was not aware of the manufacturer recommendations for cleaning and disinfection after use. Registered nurse (RN) #1 was interviewed on 11/6/24 at 8:59 a.m. RN #1 said she used germicidal wipes such as a Cavi Wipe or an alcohol pad to wipe down glucometers after every use. She said she did not know the manufacturer recommendations for cleaning and disinfecting the glucometers. She said she thought the disinfectant time for the Cavi Wipes was two minutes but was not sure. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 11/6/24 at 9:09 a.m. The DON said glucometers should be wiped with Cavi Wipes after each use and each resident has their own blood glucometers. The DON said they should be allowed to dry one to two minutes according to the recommended dry times but was not sure. The DON said this was to ensure that the blood glucometers were disinfected against blood borne pathogens according to manufacturer recommendations. The DON was interviewed again on 11/6/24 at 3:30 p.m. The DON said she provided education to the nursing staff regarding the appropriate cleaning method for using the germicidal disinfecting wipes on 11/6/24. She said the correct method was to clean with Cavi Wipes and the disinfection time was two minutes after every use.