STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ardent Health and Rehabilitation Center	501 Thornton Pkwy Thornton, CO 80229

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 - 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** 41172 Based on record review and interviews, the facility failed to ensure residents had the right to be free from physical abuse for four (#7, #8, #9 and #10) of four residents reviewed for abuse out of 12 sample residents. Resident #7 was admitted to the facility on [DATE] with diagnoses that included a history of mood disorder, depression and alcohol abuse. On 3/9/24 Resident #7 called certified nurse aide (CNA) #1, who was an agency CNA, a racial slur. CNA #1 went to Resident #7's bed, placed his forearm across the resident's left side and leaned on top of the resident. CNA #1 repeatedly told Resident #7 he needed to apologize for calling him a racial slur. CNA #1 then left the room. Resident #7 reported he cried out in pain all night following the incident. On the morning of 3/10/24 Resident #7 was transferred to the hospital when his oxygen saturation level (level of oxygen in the blood) dropped into the 70 percent (%) to 79% range. At the hospital, Resident #7 was diagnosed with multiple rib fractures and a pneumothorax (collapsed lung). Additionally, the facility failed to: - Prevent physical abuse between Resident #8 and Resident #9, both with known physical aggression, which resulted in an eye injury to Resident #8; and, - Prevent physical abuse by Resident #11, a resident with known aggressive behaviors, to Resident #10 which resulted in skin injuries to Resident #10's neck and arm. Findings include: I. Facility policy The Abuse policy, dated 2/29/24, was received from the regional director of clinical services (RDCS) on 6/20/24 at 2:12 p.m. The policy documented in pertinent part, Employees have a unique position of trust with vulnerable residents. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, (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 - Actual harm

Residents Affected - Few

intimidation, or punishment of a resident resulting in physical harm or pain, mental

anguish, deprivation of goods or services that are necessary to attain or maintain physical,

mental, or psychosocial well-being. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm.

Pre-assessment of potential residents is done during the admission process to screen for

potential signs of abusive behavior. Residents at risk for abusive situations are identified and appropriate care plans are developed. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials, according to state law. Reporting can be completed verbally or in writing. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

The facility assesses each potential resident prior to admission. This assessment includes a

behavior history. Persons with a significant history or high risk of violent behavior are carefully

screened and assessed for appropriateness of admission. If a resident experiences a behavior change resulting in aggression toward other residents, the facility will implement interventions for protection of the alleged assailant and other residents.

II. Physical abuse by certified nurse aide (CNA) #1 toward Resident #7 on 3/9/24

A. Facility investigation

The facility investigation was received from the nursing home administrator (NHA) on 6/17/24 at 12:40 p.m. The investigation documented the abuse by CNA #1 toward Resident #7 occured on 3/10/24 and an investigation was started on 3/11/24.

The investigation further documented the following:

Resident #7 had a history of aggression.

Resident #7 was interviewed by the facility on 3/12/24. Resident #7 said (CNA #1) came into his room and he called CNA #1 a racial slur. He said CNA #1 put his forearm on the resident's chest and pressed down.

CNA #1 was interviewed on 3/12/24. He said he was assigned to the resident's room. He said he had helped Resident #7's roommate to and from bed. He said Resident #7 reported some difficulty breathing and he had notified the night nurse.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #7's roommate was interviewed. The facility's investigation documented the roommate said he was not aware of what happened with his roommate. Registered nurse (RN) #1 was interviewed by the facility on 3/12/24. RN #1 said, at approximately 6:15 a.m., she went to assess Resident #7 who had complaints of pain. The resident said he had pain in his chest where a CNA had fallen on him. The resident could not elaborate due to his shortness of breath. -The facility's investigation did not include an interview with the night nurse, RN #3, who worked from 6:00 p. m. on 3/9/24 to 6:00 a.m. on 3/10/24, according to the facility's nursing schedule. The investigation documented that there were no witnesses to the event and CNA #1 said he had only gone in to assist Resident #7's roommate and nothing else. It documented Resident #7 could be resistant to care. The investigation further documented there was no mention of abuse in CNA #1's statement. The investigation documented the facility staff were educated on abuse and the police were notified on 3/12/24. The investigation documented the abuse was unsubstantiated by the facility. -However, according to the interview with the NHA, the abuse was substantiated (see interview below). A document titled Abuse Education (no date) was attached to the facility's investigation of the incident. Seventeen staff names and signatures were listed as receiving the education. B. Resident #7 1. Resident status Resident #7, age 69, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included multiple rib fractures, traumatic hemopneumothorax (blood and air in collapsed lung), depression, mood disorder and alcohol abuse. According to the 3/29/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #7 required substantial to maximal assistance with transfers and toileting and supervision with personal hygiene and bed mobility. 2. Resident interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #7 was interviewed on 6/18/24 at 2:01 p.m. Resident #7 said in the beginning of March 2024, in the evening, he had a male CNA (CNA #1) providing his care. Resident #7 said CNA #1 had been in his room, on his side of the room, multiple times that evening when his roommate called for assistance. He said he repeatedly told CNA #1 that his roommate had called, not him. Resident #7 said he called CNA #1 some bad names as CNA #1 was leaving his room. Resident #7 said CNA #1 came back into the room and laid across the left side of his chest, with his forearm pressed into the resident's left chest. He said CNA #1 yelled at him, in his face, to apologize. Resident #7 said CNA #1 then left his room. Resident #7 said he had pain in his left rib cage and was short of breath the entire evening and night. Resident #7 said he put his call light on several times but CNA #1 would come back in the room and turn it off. He said another resident in close proximity to him also turned on the call light throughout the night, but no staff came to help him. Resident #7 said he was nervous and anxious that he could be harmed again by another staff person. 3. Additional resident interview A resident, who wished not to be identified, was interviewed on 6/18/24 at 2:08 p.m. The resident resided in close proximity to Resident #7. The resident said he did not see what happened to Resident #7. He said he heard a commotion and then Resident #7 cried out in pain. He said Resident #7 cried in pain all night. The unidentified resident said both he and Resident #7 put on their call lights for help throughout the night but no one responded. He said he did not know if someone shut the call light off or the staff just did not come. He said both he and Resident #7 were up all night. 4. Record review A chest x-ray in Resident #7's electronic medical record (EMR), dated 3/7/24, two days before the incident with CNA #1, documented the resident had right airspace lung disease. He had no pneumothorax and there was no mention of an issue with his ribs. A nurse progress note, dated 3/10/24 at 12:32 a.m., documented Resident #7 had shortness of breath, dyspnea (difficulty breathing) and wheezing but no pain. The resident had a diagnosis of pneumonia and was on antibiotics. However, in report to the day nurse on the morning of 3/10/24, the night nurse reported the resident was in pain (see RN #1's interview below). Resident #7's medication administration record (MAR) for March 2024 was reviewed. The MAR documented the resident had no pain on 3/9/24. However, in report to the day nurse on the morning of 3/10/24, the night nurse reported the resident was in pain (see RN #1's interview below). The hospital note dated 3/20/24 documented Resident #7 had trauma to the left chest and had multiple rib fractures with a large left pneumothorax due to someone sitting on him. On 4/2/24 the facility's provider documented Resident #7 returned from the hospital after a traumatic pneumothorax with a chest tube and multiple rib fractures. The resident said someone sat on him. The provider documented the hospital records were unclear but laboratory results revealed evidence of a possible myocardial infarction (heart attack) as well. 5. Staff interviews (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

A voice mail message was left on 6/17/24 at 1:56 p.m. for the agency RN (RN #3) who worked from 6:00 p.m. on 3/9/24 to 6:00 a.m. on 3/10/24. There was no return call from RN #3 by the end of the survey on 6/20/24.

A voice mail message was left on 6/19/24 at 1:09 p.m. for the agency CNA (CNA #2) who worked with CNA #1 on 3/9/24 in the evening. There was no return call CNA #2 by the end of the survey on 6/20/24.

RN #1 was interviewed with the nursing home administrator (NHA) on 6/17/24 at 1:35 p.m. RN #1 said on the morning of 3/10/24 she was getting report from the night shift nurse (RN #3) who said Resident #7 had been in pain throughout the night. RN #1 said RN #3 told her it was generalized pain. RN #1 said soon after, a CNA came to her and asked her to go see Resident #7 because his oxygen saturation level was in the 70% to 79% range. RN #1 could not recall who the CNA who reported the information to her was. She said she went to see the resident and he was short of breath and had chest pain. She said she put 10 liters per minute (lpm) of oxygen on him and called 911.

RN #1 said Resident #7 could hardly speak but said CNA, my chest, my fault. RN #1 said she did not look at his chest. She said the resident was then transferred to the hospital. RN #1 said she called the hospital for a report and was told Resident #7 had multiple rib fractures to the left side and a pneumothorax. RN #1 said the resident's comment about the CNA was reported to the NHA that day.

The NHA said the hospital case manager called him on 3/11/24 and notified him that Resident #7 said a CNA had injured him. He said he went to the hospital and interviewed the resident on 3/11/24. The NHA said Resident #7 told him the male CNA (CNA #1) on 3/9/24 sat on him and pressed his forearm into the resident's chest. The resident admitted to having called CNA #1 names. The NHA said the allegation of abuse was substantiated and he notified the police and board of nursing. Additionally, he said he called CNA#1's agency and notified them that he could not return to the facility.

The medical director (MD), who was contacted prior to the end of the survey on 6/20/24 at 9:40 a.m. and was interviewed on 6/24/24 at 9:57 a.m. The MD said she became the medical director at the beginning of June 2024. The MD said a resident with fractured ribs would most likely have had pain immediately when the ribs were fractured. She said the pain could have been delayed if the resident was in shock. The MD said Resident #7's pneumothorax could have affected his oxygenation levels as well the pain. She said the pneumothorax could have happened at the time of the rib fractures or later in the night if he had taken a deep breath.

III. Resident to resident physical abuse between Resident #8 and Resident #9 on 4/14/24

A. Facility investigation

A facility investigation of physical abuse between Resident #8 and #9 on 4/14/24 was received from the NHA on 6/19/24 at 2:52 p.m. The investigation documented the following:

Resident #9 was interviewed on 4/15/24 and said Resident #8 did not like her cell phone ring tone and Resident #8 shoved her in the chest so she decided to hit him.

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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 - Actual harm Residents Affected - Few	Resident #8 was interviewed on 4/15/24. He said Resident #9 asked him for cigarettes earlier that day (4/14/24). He said when he heard her phone ring, he did not like the ring tone and told her to change it. She said no. Resident #8 said Resident #9 began to leave and he followed her and tried to hit her, and she turned around and hit him in the face. A staff witness said she was going to the kitchen and she saw Resident #8 run his wheelchair into Resident #9. She said she then saw Resident #9 hit Resident #8 in the face. She said she and other staff members pulled the residents apart. -The investigation documented both residents had a history of physical and verbal aggression. -The investigation documentation revealed the assailant was placed on frequent checks. It was unclear which resident was the assailant. B. Resident #8 1. Resident status Resident #8, age less than age 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included alcohol abuse, anxiety and seizures. According to the 4/5/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #8 was independent with bed mobility, transfers, toileting, dressing and personal hygiene. 2. Record review The behavior care plan, initiated 1/18/24, documented Resident #8 had a history of drinking at the facility, physical and verbal aggression and poor impulse control. He had a history of yelling, screaming, cursing, making verbal threats, hitting and pushing. Interventions included administering medications as ordered, assisting the resident to develop more appropriate methods of coping, encouraging expression of feelings, behavior monitoring, providing positive interactions, explaining procedures, discussing the resident's behavior, intervening as necessary to protect the rights and safety of others, approaching the resident in a calm manner, diverting the resident's attention and removing the resident from the situation. -There were no new interventions added to the care plan after the altercation on 4/14/24. C. Resident #9 1. Resident status Resident #9, age less than age 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included anxiety, depression, cocaine dependence and adult physical abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the 3/29/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #9 required substantial to maximal assistance with transfers and toileting and supervision with personal hygiene and bed mobility. 2. Record review On 3/30/24 at 11:29 a.m. the nursing progress notes documented Resident #9 was yelling and cursing at the nurse. On 4/13/24 at 10:44 a.m., one day prior to the physical abuse, the nursing progress notes documented Resident #9 was cursing at the nurse, physically attempted to remove the nurse from the room and attempted to stand and go after the nurse. The staff had to hold the resident back. The nurse documented the resident was unsafe to herself and to be around. -The nursing progress notes were reviewed between 4/13/24 and 4/14/24. No additional monitoring or intervention for Resident #9's behavior was put in place. The physical and verbal aggression care plan, initiated 8/22/23 was reviewed. The care plan documented Resident #9 had poor impulse control and a history of yelling, cursing and hitting others. Interventions included assessing and anticipating the resident's needs, monitoring behaviors, and when the resident was agitated, intervene before the agitation escalated, guiding the resident away from sources of distress and using calm conversation. -There were no new interventions added to the care plan after the altercation on 4/14/24. D. Staff interviews The NHA was interviewed with the RDCS on 6/19/24 at 2:52 p.m. The NHA said on 4/14/24 Resident #9's cell phone rang in the dining room. Resident #8 did not like the ringtone. Resident #9 attempted to leave the dining room but Resident #8 followed her and hit her in the chest. Resident #9 had sternal pain. Resident #8 then hit Resident #9 in the face resulting in broken blood vessels in Resident #8's right eye. The NHA said Resident #8 and Resident #9 had a history of verbal and physical aggression. He said there was no plan for monitoring behaviors in the dining room. The NHA said after the incident occurred, both residents were put on frequent monitoring. -However, there was no frequent monitoring documented on the care plan or in the progress notes for Resident #8 or #9. The NHA said the physical abuse toward both residents was substantiated and witnessed by staff in the dining room. IV. Resident to resident physical abuse of Resident #10 by Resident #11 on 5/31/24 A. Facility investigation (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An investigation of physical abuse to Resident #10 by Resident #11 on 5/31/24 was received from the NHA on 6/19/24 at 2:52 p.m. The investigation documented the following: Resident #10 and #11 were roommates. Resident #10 said Resident #11 had grabbed her arm and put the call light cord on her neck. A staff member interview on 5/31/24 documented she heard Resident #10 calling for help and when she went in the resident's room Resident #11 had a call light on the neck of Resident #10. Additionally the skin on the arm of Resident #10 looked like it had been twisted. A licensed nurse interview on 5/31/24 documented she went to the resident's room after a CNA came to get her. She said Resident #10 had redness to her neck and arm. Resident #11 was placed on frequent checks and then sent out to the hospital due to the risk she posed to other residents (see below). B. Resident #10 1. Resident status Resident #10, age less than age 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included major depression, heart failure and diabetes mellitus. According to the 6/13/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. Resident #10 required substantial to maximal assistance with bed mobility, transfers, toileting, personal hygiene and dressing. 2. Record review On 5/31/24 at 8:05 a.m. the nursing notes documented at 12:30 a.m. a CNA heard Resident #10 calling out for help. Upon entering room Resident #10's roommate Resident #11 was twisting skin on Resident #10's arms and had the call light wrapped around Resident #10's neck. Resident #10 was extremely frightened. Slight redness was noted on the resident's arms and on the neck. Resident #10 reported slight pain that quickly resolved. Frequent checks were performed to reassure Resident #10 throughout the night. Resident #10 reported anxiety which improved when the resident was informed a CNA would stay until the roommate was removed and that staff would check on her through the night. -There was no care plan in the resident's EMR related to the abuse. C. Resident #11 1. Resident status Resident #11, age less than age 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia, anxiety and agitation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to the 3/31/24 MDS assessment, the resident had severe cognitive impairment and a BIMS score was not completed. She had short and long term memory loss with moderate impairment of daily decision making, disorganized thinking and physical behavior toward others. Resident #11 required substantial to maximal assistance with toileting, personal hygiene, dressing and supervision with transfers and bed mobility. 2. Record review On 5/22/24 at 7:36 p.m. the provider documented the resident had increased aggression and a history of aggressive behavior. On 5/30/24 at 5:09 p.m. the nursing notes documented the resident was fascinated by an ambulance that had come to the facility and she tried to get on the gurney brought by the emergency medical services (EMS) staff. The resident could not be redirected and became aggressive, pushing and pinching the staff. The nurse tried to comfort the resident but was pushed away. -There was no behavior care plan in place until 6/10/24, after the physical altercation with Resident #10, despite Resident #11 exhibiting aggressive physical behaviors prior to the incident (see Resident #11's care plan below). On 5/31/24 at 7:53 a.m. the nursing progress notes documented that at approximately 12:30 a.m., Resident #10 called out for help. Resident #11 was found by a CNA with the call light wrapped around the neck of Resident #10 and she was pulling the call light. Resident #10 said Resident #11 had also grabbed her by the forearms and twisted her skin. The nurse called administration and a decision was made to send Resident #11 to the hospital for the safety of Resident #11 and other residents. On 5/31/24 at 8:15 a.m. an SBAR (situation, background, assessment recommendation) note documented Resident #11 was sent to the hospital due to her behavior. The note documented she needed close observation for resident, staff, and other resident safety. The resident returned that afternoon at an undocumented time. On 5/31/24 at 6:12 p.m. The nursing notes documented the resident was moved to a different unit due to the incident and was monitored. The behavior care plan, initiated 6/10/24 (10 days after the incident with Resident #10) documented Resident #11 had potential to be physically aggressive with a history of harm to others. The goal was the resident would seek out a staff member when agitation occurred. Interventions included administering medications, analyzing time of day, places , triggers, circumstances and what deescalated behaviors, assessing and addressing sensory deficits, anticipating the resident's needs, Modifying the environment, such as dim lights and keeping the door closed, monitoring and documenting behaviors and interventions, monitoring and documenting signs and symptoms of the resident posing danger to herself or others, when the resident was agitated, intervening before agitation escalated, guiding the resident away from distress, engaging with the resident calmly and re-approaching the resident later. D. Staff interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA was interviewed with the RDCS on 6/19/24 at 2:52 p.m. He said Resident #10 reported Resident #11 put a call light on her neck and pinched her arm. The NHA said Resident #11 had a history of pacing and grabbing furniture. He said Resident #10 had redness to her arm and neck. He said the abuse was unsubstantiated because Resident #11 had dementia. He said he moved Resident #11 to a private room after the altercation.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review, and interviews, the facility failed to provide four of four residents (#3, #4, #5, and #12) out of 12 sample residents, with the necessary treatment and services to manage pressure injuries and minimize pressure injury risks. RESIDENT #3 Record review and interview revealed Resident #3 was hospitalized seven times and readmitted to the facility six times between January and June 2024. During this time, the resident developed pressure injuries to his sacrum, ischium, left and right heels, left ankle, and scrotum which ranged from stage 2 (partial thickness skin loss) to stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle), as well as osteomyelitis (inflammation of the bone due to infection) of the sacral wound. Record review revealed the facility failed to assess the resident's pressure injuries on his readmission to the facility from the hospital on at least five occasions (1/18, 3/7, 3/19, 4/29, and 5/20/24) and failed to obtain and implement treatment orders timely. -In January, upon the resident's readmission on 1/18/24, nursing documented open wounds to the resident's right and left clavicle and coccyx per interview with the director of nursing (DON). However, the wounds were not assessed and no treatment orders were obtained until the following week. Further, the resident's skin assessments on 1/19, 1/20, and 1/21/24 incorrectly documented no skin issues. -In March, upon the resident's first readmission on 3/7/24, nursing documented a stage 2 sacral wound and an unstageable right heel wound, but the wounds were not assessed and no treatment orders for the wounds were obtained. Upon the resident's second readmission on 3/19/24, the resident's wounds were described as right heel stage 3, left heel deep tissue injury, and sacrum macerated and red. There was no documentation of dressing changes and no wound treatment orders until 3/27/24. Per record review and interview, in March, the resident was in the facility for 13 days (3/7 - 3/12/24 and 3/19 - 3/27/24) without treatment orders for wounds on his sacrum, and right and left heels. On 4/1/24, the resident was readmitted to the hospital with a diagnosis of osteomyelitis of the sacral wound. The resident was hospitalized for almost a month. In April, upon the resident's readmission on 4/29/24, there were treatment orders for his sacrum, heels, and new ischial wound and documentation of treatments, but no evidence the wounds were assessed and monitored before he returned to the hospital on 5/15/24. In May, upon the resident's readmission on 5/20/24, the readmission nursing assessment documented ankle stage 3, right heel unstageable, left heel stage 3, sacral stage 4, right gluteal fold unstageable, and scrotum stage 2. The assessment documented the initiation of a wound vacuum for the sacral wound but no new wound orders. There was no monitoring or description of the wounds by nursing staff before the resident's readmission to the hospital on 6/13/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER: Ardent Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Thornton Pkwy Thornton, CO 80229	

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's repeated failures to assess Resident #3's wounds on readmission, monitor the wounds, and ensure timely treatment orders created the likelihood of serious harm to Resident #3, as well as other current and future residents at risk for pressure injuries if the facility's failures were not immediately corrected. RESIDENTS #5, #12, AND #4 Further record review and interview revealed additional failures in the facility's management of residents' pressure injuries. Specifically, the facility failed to ensure: -Resident #5's wounds were assessed on admission, the resident was accurately assessed for risk of pressure injury development, and timely pressure prevention interventions and treatment were put in place; -Resident #4, who had four pressure injuries from stage 3 (full-thickness tissue loss) to stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle), had an air mattress that was inflated appropriately to prevent increased pressure; and, -Resident #12's pressure injuries were assessed on admission and treatment was ordered timely and provided. Findings include: I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy Record review and interview revealed Resident #3 was hospitalized seven times and readmitted to the facility six times between January and June 2024. During this time, the resident developed pressure injuries to his sacrum, ischium, left and right heels, left ankle, and scrotum which ranged from stage 2 (partial thickness skin loss) to stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle), as well as osteomyelitis (inflammation of the bone due to infection) of the sacral wound. Record review revealed the facility failed to assess the resident's pressure injuries on his readmission to the facility from the hospital on at least five occasions (1/18, 3/7, 3/19, 4/29, and 5/20/24) and failed to obtain and implement treatment orders timely. -In January, upon the resident's readmission on 1/18/24, nursing documented open wounds to the resident's right and left clavicle and coccyx per interview with the director of nursing (DON). However, the wounds were not assessed and no treatment orders for the wounds were obtained until the following week. Assessments 1/19, 1/20, and 1/21/24 incorrectly documented no skin issues. -In March, upon the resident's first readmission on 3/7/24, nursing documented a stage 2 sacral wound and an unstageable right heel wound, but the wounds were not assessed and no treatment orders for the wounds were obtained. Upon the resident's second readmission on 3/19/24, the resident's wounds were described as right heel stage 3, left heel deep tissue injury, and sacrum macerated and red. There was no documentation of dressing changes and no wound treatment orders until 3/27/24. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per record review and interview, in March, the resident was in the facility for 13 days (3/7 - 3/12/24 and 3/19 - 3/27/24) without treatment orders for wounds on his sacrum, right and left heels. On 4/1/24, the resident was readmitted to the hospital with a diagnosis of osteomyelitis of the sacral wound. The resident was hospitalized for almost a month. In April, upon the resident's readmission on 4/29/24, there were treatment orders for his sacrum, heels, and new ischial wound, but no evidence the wounds were assessed and monitored before he returned to the hospital on 5/15/24 for severe sepsis. In May, upon the resident's readmission on 5/20/24, the readmission nursing assessment documented ankle stage 3, right heel unstageable, left heel stage 3, sacral stage 4, right gluteal fold unstageable, and scrotum stage 2. The assessment documented the initiation of a wound vacuum for the sacral wound but no new wound treatment orders. There was no monitoring or description of the wounds by nursing staff before the resident's readmission to the hospital on 6/13/24. The facility's repeated failures to assess Resident #3's wounds on readmission, monitor the wounds, and timely obtain and implement treatment orders created the likelihood of serious harm to Resident #3, as well as other current and future residents at risk for pressure injuries if the facility's failures were not immediately corrected. B. Facility notice of immediate jeopardy On 6/18/24 at 3:42 p.m., the nursing home administrator (NHA) was informed of the findings of immediate jeopardy under F686, Pressure Injuries. C. Facility plan to remove immediate jeopardy The facility plan to remove immediate jeopardy read: The identified Resident (#3) is currently at the hospital; therefore, no individualized plan of correction is indicated. This Resident will not be returning to the community. The community has identified two other Residents with pressure injuries. The director of nursing (DON) completed pressure injury assessments on these 2 Residents and updated the plans of care as indicated. Current treatment orders were verified and treatment was completed as ordered. On 6/19/2024, a community-wide audit of all residents was completed by the DON or designee to obtain a baseline on current skin concerns in the community. Any identified area was corrected upon discovery. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/19/2024, the DON completed an audit to ensure all treatments, supplies, and equipment were readily available for pressure injury treatments. Additionally, the Director of Clinical Operations completed an audit of all air mattresses and support surfaces to ensure proper use in accordance with (the) manufacturer's recommendations or resident preferences. All identified areas were corrected upon discovery. Beginning 6/18/2024, the DON or designee initiated education with nursing staff regarding proper identification, documentation, and monitoring of pressure ulcers, as well as implementing interventions to prevent breakdown and completion of treatments as ordered for resident's skin injuries. Education to be provided to agency staff prior to the next scheduled shift. Beginning 6/19/2024, (the) DON or designee (is) to complete wound rounds weekly and ensure documentation is inputted in (the) electronic health record weekly. Beginning 6/19/2024, DON or designee (is) to complete wound dressing change observations and complete chart review two times a week for one month, then weekly for two months wound documentation for two residents to ensure that orders in place and are being followed as written, that staff is following appropriate infection control practices, that the physician is notified as needed, and that documentation is consistent throughout the chart. Identified concerns to be addressed with staff. Beginning 6/19/2024, (the) Nurse consultant or designee (is) to complete (a) monthly review of (the) resident's wound documentation to ensure that it is consistent with documentation from the wound physician and that the physician is being contacted as necessary for the wound. Identified concerns to be addressed with DON/designee. Beginning 6/19/2024, any residents admitted to the facility or returning from the hospital will be assessed for any area of skin breakdown. Any areas identified requiring treatment will have orders verified or obtained and wound care appointments will be transcribed and overseen by nurse leadership. A review to include an additional skin check will be completed. DON or designee to report on wound data monthly in the quality assurance performance improvement QAPI meeting. Identified concerns to be tracked and trended as needed. D. Removal of immediate jeopardy The facility plan was accepted by the state survey agency on 6/19/24 at 12:48 p.m., based on the systemic changes outlined in the plan to ensure pressure injuries would be assessed, monitored, and treated, and oversight planned to ensure compliance. The immediate jeopardy situation was removed; however, the deficient practice remained at level G, isolated, actual harm. II. PRESSURE INJURIES - CLASSIFICATION OF INJURIES AND FACILITY EXPECTATIONS A. Classification of pressure injuries According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www. internationalguideline.com/guideline on 6/23/24, Pressure ulcer classification is as follows: (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. B. Facility expectations in the management of pressure injuries and pressure injury risks. 1. Facility policy The facility's Pressure Injury Policy, dated 3/10/23, was received from the regional director of clinical services (RDCS) on 6/20/24 at 2:12 p.m. The policy read, in pertinent part: Purpose: To assess and implement interventions as appropriate to reduce the likelihood of (the) development of pressure injuries and that a resident who has a pressure injury receives appropriate care and services to promote healing and to prevent additional pressure injuries. Assessment: Using a standardized Braden Risk Assessment Tool, assess a resident's pressure injury risks upon admission. Conduct a thorough skin assessment. The facility will complete this assessment upon admission and weekly thereafter unless otherwise indicated. Daily monitoring with accompanying documentation. Protecting against the effects of pressure, friction, and shear. Reduce pressure over bony prominences by offloading and positioning. Evaluate the need for a pressure-reducing mattress or overlay. The facility will initiate and follow treatment modalities as ordered by the primary physician. 2. Staff interviews a. The DON and the regional director of clinical services (RDCS) were interviewed on 6/18/24 at 9:28 a.m. The DON said she expected a wound assessment would be completed within the first few hours after the resident was admitted . She said the assessment should include general size, color, and whether there was drainage or signs of infection. The DON said nurses were responsible for obtaining orders before the wound physician rounds. She said the nurse should check for any orders sent with the resident from the hospital and the nurse should call the doctor for orders if the resident had a wound and no orders existed. The DON said measurements should be obtained each week by the wound team with measurements and a description of the resident's wounds, even if the resident is being seen by an outside wound clinic. The DON said nursing staff should monitor and assess the resident's wounds as dressing changes are performed. Treatments and dressing changes should be documented on the treatment administration record (TAR) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Licensed practical nurse (LPN) #1 was interviewed on 6/20/24 at 12:55 p.m. LPN #1 said the skin assessment should be done the same day as the resident's admission. LPN #1 said she prioritized this and completed it within an hour of admission. LPN #1 said if there was something abnormal, she reported the observations to the registered nurse (RN) for a thorough assessment and the RN would call the physician. c. Registered nurse (RN) #1 was interviewed on 6/20/24 at 1:00 p.m. RN #1 said she assessed residents' skin condition at admission and readmission and tried to complete the assessment within an hour of admission. RN #1 said if a resident's skin condition was abnormal, she would measure and document a description of the wounds and contact the physician to obtain orders the same day. III. RESIDENT #3 A. Resident status Resident #3, age 69, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), the resident's diagnoses included leukemia, diabetes, kidney disease, and cerebrovascular disease (conditions affecting blood vessels and flow in the brain). The 3/25/24 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. It documented that the resident was at risk for the development of pressure injury and had three unhealed, unstageable pressure ulcers. Resident #3 required a pressure-reducing device for his chair and bed, nutrition interventions to manage skin problems, and pressure injury care, including the application of ointments/medications. Resident #3 required partial assistance with eating and was dependent on staff for repositioning in bed, transferring, and bathing. B. Record review and interviews revealed Resident #3 developed six wounds. The facility failed to provide the resident with the necessary care and services to prevent the pressure wounds from developing and worsening. Specifically, the facility failed repeatedly to assess Resident #3's wounds on readmission, monitor the wounds, and timely obtain and implement treatment orders as expected. 1. January - February 2024 a. The resident was hospitalized ,d+[DATE] - 1/8/24 for sepsis. On 1/8/24, Resident #3 was readmitted to the facility. On 1/9/24, the wound physician's progress note revealed Resident #3 had developed a non-pressure wound on the left buttock, described as moisture-associated skin damage (MASD) partial thickness which measured 1.3 cm by 1.3 cm by 0.1 cm. Treatment orders to use a foam silicone border every two days were initiated. b. The resident was hospitalized ,d+[DATE] - 1/18/24 for urinary retention (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/18/24, Resident #3 was readmitted to the facility. The hospital physician's note revealed Resident #3 had a neck/collar area pressure injury which started at the nursing facility on 1/12/24 from his cervical collar. (The note did not mention a non-pressure wound on the left buttock noted 1/8/24.) Assessment failures: Record review revealed no assessment of Resident #3's wounds upon readmission to the facility on [DATE]. See facility policy above. In an interview on 6/18/24 at 9:28 a.m. with the DON and the regional director of clinical services (RDCS), the DON confirmed the 1/18/24 nursing assessment documented three open wounds (left clavicle, right clavicle, and coccyx) but there was no documentation these wounds were assessed. Moreover, the RDCS said the nurse on 1/19/24 and 1/20/24 documented the resident's skin was intact and the DON said an assessment completed on 1/21/24 documented no skin issues. Treatment failures: The resident's record revealed no treatment orders until 1/23/24. See facility expectations above. In the interview on 6/18/24 at 9:28 a.m., the DON said nurses were responsible for obtaining orders before the wound physician rounds. She said the nurse should check for any orders sent with the resident from the hospital and the nurse should call the doctor for orders if the resident had a wound and no orders existed. c. Documentation of the presence of additional wounds 1/31/24, 2/6/24, 2/13/24 On 1/31/24, the wound physician's progress note revealed: -Non-pressure wound left buttock, partial thickness, MASD, 0.8 cm by 0.3 cm by 0.1 cm. -Non-pressure wound left neck, full thickness, 5.5 cm by 1.2 cm by 0.3 cm. -Pressure wound of right heel, full thickness, unstageable, 2.2 cm by 2.2 cm x non-measurable depth. The heel wound was noted to be greater than 13 days in duration. However, the 1/25/24 wound notes did not reveal a heel wound. On 2/6/24, the wound physician's progress note revealed: -Non-pressure wound left buttock had resolved. -Non-pressure wound left neck healing and measured 3.0 cm by 0.7 cm by 0.3 cm. -Non-pressure wound of right heel resolved. On 2/13/24, the wound physician's progress note revealed: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Non-pressure wound left neck full thickness, cauterization procedure for abnormal granulation tissue. -Non-pressure wound left ischium full thickness, measured 3.9 cm by 2.0 cm by 0.1 cm. -Pressure wound right heel, undetermined thickness, unstageable measured 1.1 cm by 1.5 cm by non-measurable. 2. March 2024 a. The resident was hospitalized from 2/14 to 3/7/24, for a urinary tract infection and surgical revision. He was readmitted to the facility on [DATE] until 3/12/24 when he was hospitalized again until 3/19/24 for urinary retention and suprapubic catheter placement. The resident was readmitted to the facility on ,d+[DATE] until 4/1/24 when he returned to the hospital. Failures on readmission 3/7/24 and 3/19/24. Assessment failures 3/7 to 3/12/24 and 3/19 to 3/27/24: The nursing admission assessment on readmission 3/7/24 at 5:50 p.m. revealed a stage 2 sacrum wound and an unstageable right heel wound. The nursing assessment on readmission on 3/19/24 revealed a right thigh skin tear, right heel stage 3, left heel deep tissue injury, and sacrum macerated and red. See facility policy above. In an interview on 6/18/24 at 9:28 a.m. with the DON and the regional director of clinical services (RDCS), the DON confirmed there was no description of the resident's wounds on his readmission from 3/7/24 to 3/12/24. Further record review revealed no description of the resident's wounds on readmission from 3/19/24 to 3/27/24 when Resident #3 was seen by the wound physician (see below). On 3/30/24, nursing notes at 4:03 p.m. and on 3/31/24 at 5:42 a.m. described the resident's coccyx wound as having odor. However, there was no documentation of an assessment or follow-up. Treatment failures 3/7 to 3/12/24 and 3/19 to 3/27/24: Record review revealed no wound treatment orders during the resident's first readmission in March. Further, record review revealed no treatment orders during the resident's second readmission on 3/19 until 3/27/24 when the resident was seen by the wound physician. See facility expectations above. In the interview on 6/18/24 at 9:28 a.m., the DON confirmed there were no wound treatment orders from the resident's readmission from 3/7/24 to 3/12/24 and no wound treatment orders from his readmission from 3/19 until 3/27/24. She said nurses were responsible for obtaining orders before the wound physician rounds. She said the nurse should check for any orders sent with the resident from the hospital and the nurse should call the doctor for orders if the resident had a wound and no orders existed. (continued on next page)

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F 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In addition, a review of the treatment administration record (TAR) revealed it did not have documentation of dressing changes from 3/19 to 3/26/24. See facility expectations above. The DON said in the interview on 6/18/24 at 9:28 a.m., that all treatments and dressing changes should be documented on the TAR.

c. Documentation of wounds 3/27/24

The wound physician's progress note included the following description: sacrum, unstageable due to necrosis 10 centimeters (cm) x 11 cm x 0.1 cm depth; right heel unstageable 2.0 cm x 3.0 cm, depth not measurable; and left heel unstageable 2.5 cm x 3.0 cm, depth not measurable. The physician also identified a non-pressure wound (moisture-associated skin damage) greater than seven days on the resident's scrotum 3.0 x 2.0 x 0.1 which was not previously identified by the facility.

3. April 2024

a. The resident was hospitalized from 4/1/24 to 4/29/24 for pressure ulcers and osteomyelitis of the sacral wound. The hospital admission history and physical revealed a computerized tomography (CT) on 4/1/24 demonstrated coccygeal osteomyelitis (from sacral ulcer) as the primary infectious source.

Failures on readmission to the facility 4/29/24:

Record review revealed there were treatment orders for his sacrum, heels, and new ischial wound, but there was no evidence the wounds were assessed and monitored before he returned to the hospital on 5/15/24.

The DON in the interview on 6/18/24 at 9:28 a.m. said the resident was being seen by an outside wound clinic after 4/30/24; however, she said the resident should have continued to be seen by the wound team weekly at the facility.

The DON said measurements should have been obtained each week by the wound team with a description of the resident's wounds at the facility. The DON said nursing staff should have monitored and assessed the resident's wounds as dressing changes were performed.

On 5/6/24, Resident #3's outside facility wound clinic visit physician progress note revealed the following: sacral pressure injury stage 4; left ischial pressure injury, unstageable; left heel pressure injury, unstageable; right heel pressure injury, unstageable; left ankle pressure injury, unstageable and left foot (metatarsal) pressure injury, unstageable.

4. May - June 2024

a. The resident was hospitalized on [DATE] for severe sepsis and readmitted to the facility on [DATE]. He was readmitted to the hospital on 6/13/24 and remains hospitalized .

The resident's readmission nursing assessment on 5/20/24 documented: ankle stage 3; right heel unstageable; left heel stage 3; sacral stage 4; right gluteal fold unstageable; and scrotum stage 2. The assessment also documented the initiation of a wound vacuum (wound vac) for the sacral wound. Treatment orders were resumed from the resident's previous admission without new orders.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER: Ardent Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Thornton Pkwy Thornton, CO 80229	

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Failures on readmission to the facility from 5/20/24 to 6/13/24: Assessment failures: There was no monitoring or description of the wounds by nursing staff before the resident's readmission to the hospital on 6/13/24. See above. The DON in the interview on 6/18/24 at 9:28 a.m. said the resident was being seen by an outside wound clinic after 4/30/24. However, she said the resident should have continued to be seen by the wound team weekly at the facility. The DON said measurements should have been obtained each week by the wound team with a description of the resident's wounds at the facility. The DON said nursing staff should have monitored and assessed the resident's wounds as dressing changes were performed. The outside wound clinic RN (WCRN) was interviewed on 6/18/24 at 1:00 p.m. The WCRN said Resident #3 was seen at the clinic by the wound physician once per week and was last seen at the clinic on 6/5/24. She said Resident #3's wounds were: sacral, stage 4; left heel, stage 3, right heel, unstageable; left ankle, stage 3, and ischial, stage 4. The WCRN said if there were gaps in the treatment of the wounds, it could have led to the worsening of Resident #3's wounds. Treatment failures: The WCRN said the wound vacuum (initiated on 5/20/24) was not on the resident when he arrived for the visit on 6/5/24. The WCRN said the facility sent the wound vac machine the week prior, however, it was not working and was out of batteries. Certified nurse aide (CNA) #3 was interviewed on 6/20/24 at 12:36 p.m. CNA #3 said she sometimes noticed residents' bandages that needed replacement and she told the nurse when this occurred. CNA #3 said she bathed Resident #3 on 6/11/24 and his dressings were labeled with the date of the last dressing change on 6/7/24. CNA #3 said she notified the nurse and the DON that Resident #3's dressings had not been changed. The DON and RDCS were interviewed a second time on 6/20/24 at 1:16 p.m. The DON said a CNA told her Resident #3's dressings had not been changed for several days last week. The DON said she did not remember the name of the CNA, the nurse, or the dates. The DON said she told the nurse and the dressing was changed. The DON said she told all staff that dressings needed to be changed as ordered. She said she provided education and began monitoring staff for dressing change completion but she did not have documentation of the education provided or the monitoring she had completed. The DON said she did not know if Resident #3's wounds had progressed before his hospitalization on [DATE]. The RDCS said there was no documentation describing the wounds after the missed dressing changes. IV. Resident #5 A. Resident status (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #5, less than age 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included infection of the right upper extremity stump, sacrum pressure ulcer, diabetes mellitus, and left and right above-the-knee amputation. According to the 4/23/24 minimum data set (MDS) assessment, the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. Transfers did not occur according to the assessment. Resident #5 required substantial to maximum assistance with bed mobility and supervision with personal hygiene. She was dependent on staff for toileting. The assessment documented Resident #5 had a pressure injury to the sacrum. It further documented the resident's pressure injury was unstageable and pressure injury care and treatment were in place. The assessment documented the resident was frequently incontinent. B. Record Review On 4/19/24 the Nursing Admit Data Collection Tool documented the resident had pressure injuries to the right and left gluteal folds. There was no further description of the wounds. The Braden assessment, dated 4/22/24, documented the resident was not at risk for pressure injuries. The assessment documented the resident had no sensory impairment, was rarely moist, chairfast, had slightly limited mobility, adequate nutrition, and had no problems with friction. -However, the resident had current pressure injuries as documented on 4/19/24 and had diabetes mellitus. Further, she required substantial assistance with bed mobility and was frequently incontinent. On 4/22/24 at 12:15 a.m. the provider documented the resident still did not have an air mattress. The provider spoke with the DON about getting an air mattress. The provider documented that wound treatment orders were given. On 4/23/24 at 12:15 a.m. the provider documented the air[TRUNCATED]

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41172 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care. Findings include: I. Cross-referenced citations Cross-reference F686: The facility failed to ensure pressure injuries were assessed and interventions were implemented timely to prevent worsening of the wounds and infection. The facility failed to ensure wound treatment was implemented as ordered for a resident who developed a wound infection with osteomyelitis (inflammation of the bone due to infection). The facility's failure to assess and treat pressure injuries created an immediate jeopardy (IJ) situation with actual serious harm. Cross-reference F600: The facility failed to prevent abuse resulting in a G level citation, isolate, with actual harm. II. Facility policy and procedure The facility QAPI policy was requested from the nursing home administrator (NHA) on 6/20/24 at 2:10 p.m. -The policy was not received by the end of the survey on 6/20/24. III. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies. F686 Pressure injuries: During a recertification survey on 4/19/22, F686 was cited at a G level scope and severity, isolated, actual harm. F600 Abuse prevention: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a recertification survey on 10/26/23, F600 was cited at a G level scope and severity, isolate, actual harm. During a recertification survey on 3/7/24, F600 was cited at a D level scope and severity, potential for more than minimal harm, isolated. F867 QAPI During a recertification survey on 7/21/22, F867 was cited at an E level scope and severity, a potential for more than minimal harm, pattern. IV. Interviews The nursing home administrator (NHA) was interviewed on 6/20/24 at 2:10 p.m. The NHA said residents with pressure injuries were reviewed at QAPI. However, he said the lack of assessment and timely treatment of wounds identified during the survey was an eye opener. The NHA said the facility had missed things in their review of the wounds. The NHA said he did not have a clinical background and therefore did not check any of the clinical information himself. The NHA said the staff needed more training on abuse and how to appropriately prevent, report and intervene in abuse situations. He said the facility additionally needed to keep a better record of training that was completed with staff on abuse. The medical director (MD) was interviewed on 6/24/24 at 9:57 a.m. The MD said she had become the medical director of the facility two weeks ago (beginning of June 2024). She said the facility had been using a lot of agency staff and they were working on recruiting staff for hire by the facility. She said she felt this contributed to the facility's failures. The MD said she knew the facility had changed wound care providers recently, but she was not aware wounds were not being assessed by the facility or treated timely. The MD said she did not recall the staff to resident abuse when a staff person laid on a resident intentionally, causing multiple rib fractures and a pneumothorax. However, she said she had not been with the facility long.