| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065206 | A. Building<br>B. Wing | 04/24/2024 |

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| Rowan Community, Inc | 4601 E Asbury Cir<br>Denver, CO 80222 |

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032<br><br>Based on interviews and record review, the facility failed to ensure prompt action was taken to honor a request for the resident's personal and medical records by the resident and legal representative for one (#52) of one resident reviewed for medical records requests out of 33 sample residents.<br><br>Specifically, the facility failed to allow Resident #52 and the resident's legal representative the right to obtain a copy of the resident's medical records or any portions of the electronically maintained record upon request and within two (2) working days of a verbal or written request for the resident's medical records.<br><br>Findings include:<br><br>I. Resident #52<br><br>A. Resident status<br><br>Resident #52, under the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included bipolar disorder (a mental illness that causes unusual shifts in the person's behavior), anxiety disorder and cerebrovascular disorder (a condition that affects blood flow to the brain).<br><br>The 3/15/24 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. The resident required extensive assistance with bathing, dressing and personal hygiene. The resident did not have any behaviors or rejection of care.<br><br>B. Record review<br><br>A medical durable power of attorney (MDPOA) for healthcare decisions, signed on 1/6/24 by Resident #52, read in pertinent part: I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care services or treatment, including hospitals, nursing homes, and any other facilities or treatment centers or programs to release to my agent all information or photocopies of any record which my agent may request.<br><br>B. Resident and legal representative interview<br><br>(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 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #52 was interviewed on 4/22/24 at 2:30 p.m. Resident #52 said she made her sister her MDPOA and wanted her MDPOA to make all her medical decisions because she did not understand medications and medical matters and she needed help to make good decisions. Resident #52 said it made her anxious and worried when the nursing staff tried to discuss medical issues with her and asked her to make medical decisions on her own without her MDPOA present.<br><br>Resident #52's MDPOA was interviewed on 4/23/24 at 10:42 a.m. The MDPOA said she had filed a couple of requests for Resident #52's medical records asking for specific information. She said it took the facility approximately 30 days to respond to the first request for medical records and she did not get all of the documents she had requested. She said, additionally, the facility did not provide an explanation of why the facility had not provided all of the requested documents. She said a grievance form was filed and the facility did not provide a written response on how they resolved the grievance. The MDPOA said the failure to provide medical records as requested was not resolved (cross-reference F585 for failure to respond to grievances).<br><br>The MDPOA said, in addition to the request made on 3/5/24, she made an additional request for records on 4/21/24 and she still had not received the records. She said the facility returned the request to her because she had attached a page explaining the types of documents requested. She said the facility told her she needed to rewrite the request because the request needed to be written on one sheet of paper and if she needed more space she could write on the back of the form.<br><br>The MDPOA was interviewed again on 4/24/24 at 5:12 p.m. The MDPOA said she still had not received the medical records documents she requested on 4/21/24.<br><br>C. Records review<br><br>A review of a grievance form dated 3/18/24 revealed Resident #52 and her MDPOA requested medical records on 3/5/24 and they had not received the requested documents by 3/18/24. When the resident's representative complained the facility requested the representative fill out a new request form.<br><br>The grievance form documented that the requested medical records were sent to the MDPOA by email and the grievance was resolved.<br><br>-However, the MDPOA disagreed with the grievance finding and said that she did not receive all of the requested documents.<br><br>The MDPOA provided a copy of a records request sent to the facility by email on 4/22/24 at 7:18 a.m. The requested documents included documentation of resolutions for all grievances forms filed with the facility from 11/2/21 through 4/22/24, all speech therapy and any other therapy notes and evaluations from 1/1/24 through 4/22/24 and laboratory results from 4/11/24 through 4/22/24.<br><br>The facility responded by email on 4/23/24 at 10:07 a.m. The email read in pertinent part, I received your request, unfortunately, I will need you to fill out another request. The dates are required to be provided on the form. If there is not enough room on the sheet, can you please provide additional information on the back of the form.<br><br>-However, the facility did not permit the resident and the MDPOA the right to clarify the medical records request verbally.<br><br>(continued on next page) |

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | D. Staff interviews<br><br>The nursing home administrator (NHA) was interviewed on 4/24/24 at 1:10 p.m. The NHA said the facility had some difficulty with records management and it was taking longer than usual to process records requests. The NHA said the facility had hired a new director of medical records (DMR) and a records request should take approximately 10 days to process. The NHA said they had received the records request for Resident #52 and would process the request as soon as possible.<br><br>-However, the resident/ resident representative had the right to request copies of the resident's medical records verbally or in writing and receive the requested records within two working days with advance notice to the facility. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960<br><br>Based on record review and interview, the facility failed to ensure two (#209 and #52) of two residents out of 33 sample residents were provided prompt efforts by the facility to resolve grievances.<br><br>Specifically, the facility failed to:<br><br>-Ensure Resident #209' s complaint about meals not being served at a palatable temperature;<br><br>-Support Resident #52' s right to file any grievance (written or verbally) without the fear of feeling retaliation;<br><br>-Ensure that all written grievance decisions included the date the grievance was received, a summary statement of the resident' s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident' s concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was provided to the resident;<br><br>-Ensure Resident #209 and Resident #52 received written responses to verbal and written grievances; and,<br><br>-Establish a grievance policy that included all required elements per the regulations.<br><br>Findings include:<br><br>I. Facility policy and procedures<br><br>The Grievances Policy, dated [DATE], was provided by the corporate director of clinical services (CDCS) on [DATE] at 5:13 p.m. It read in pertinent part, To provide residents and responsible party with information on the facility grievance procedure. To ensure that residents are afforded their right to file a grievance without discrimination or reprisal and that such grievance shall be responded promptly and in written form.<br><br>A resident, family member, staff member or visitor may file a grievance at any time with an appropriate staff member or supervisor regardless of cognitive status, mental health diagnosis, or physical disability. There is no set time frame or minimum amount of time in which it must be filed except for those required under Elder Justice Law (see Abuse Policy).<br><br>The administrator may assign the responsibility of investigating grievances and complaints<br><br>to the appropriate department.<br><br>Upon the receipt of a Grievance and Complaint Report or Complaint Concern form, the<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Social Services Director or designee will begin an exploration into the allegations/concerns. The appropriate department director will be notified of the nature of the complaint and that follow up is necessary. The investigation and report will include, as each may apply the date and time the incident took place, the circumstances surrounding the incident, where the incident took place, the names of any witnesses and their account of the incident, the resident' s account of the incident, the employee' s account of the incident, accounts of any other individuals involved ( employee' s supervisor) and recommendations for corrective action if not already remedied .<br><br>The resident, or person acting on behalf of the resident, will be informed of the findings of<br><br>the investigation, as well as any corrective actions recommended, within ten (10) working<br><br>days of the filing of the grievance or complaint.<br><br>-The grievance policy failed to include the resident's right to file a grievance in writing or orally, file a grievance anonymously and obtain the review in writing.<br><br>II. Resident #209<br><br>A. Resident status<br><br>Resident #209, age 67, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included bipolar disorder (mental illness that causes unusual shifts in the person's behavior) and generalized anxiety disorder.<br><br>The [DATE] 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 independent for eating. She required partial/moderate assistance for oral hygiene and was dependent on staff for toileting.<br><br>B. Resident interviews<br><br>Resident #209 was interviewed on [DATE] at 10:54 a.m. She said she had recently been admitted to the facility and had noticed the food was served cold for most meals. Resident #209 said she had filed grievances about the concern but it was never resolved and she was still receiving cold food at meals (cross-reference F804 for failure to serve food that was palatable in temperature).<br><br>Resident #209 was interviewed again on [DATE] at 1:53 p.m. She said her food was still arriving cold and she had only had two fairly warm meals over the past week.<br><br>C. Record review<br><br>A grievance, filed by Resident #209 on [DATE], revealed she had a concern with her meals being served cold. The food and nutrition manager (FNM) documented the concern was passed on to the dietary manager (DM). The DM documented the food was being made at the proper temperature and recommended the resident eat in the dining room for faster service.<br><br>-Resident #209' s preference to eat in her room was not taken into account and there was no action taken to address the resident's complaint of food being served cold and unpalatable food.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | D. Staff interviews<br><br>Certified nurse aide (CNA) #4 was interviewed on [DATE] at 2:12 p.m. She said breakfast trays were served late that morning because there were only two CNA' s on the floor and they were providing care for a resident that required care in pairs. CNA #4 said one resident did not get her breakfast until after 9:30 a.m. and then had to order a special breakfast because the tray had sat for so long it was cold.<br><br>The DM was interviewed on [DATE] at 1:29 p.m. The DM said the kitchen served the residents in the dining room first and then the room trays were sent out for delivery to residents who ate in their rooms. The DM said there were a lot of room trays so it sometimes took the kitchen staff time to plate and get all the trays for the units on the food delivery carts. The DM said the kitchen was working on fixing the room tray deliveries and it could sometimes take a long time for the trays to get delivered by the nursing staff depending on what other duties they had to complete. The DM could not provide evidence the facility had resolved Resident #209' s grievance regarding cold food in a manner that was satisfactory to the resident.<br><br>41032<br><br>III. Resident #52<br><br>A. Resident status<br><br>Resident #52, under the age of 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included bipolar disorder (a mental illness that causes unusual shifts in the person's behavior), anxiety disorder and cerebrovascular disorder (a condition that affects blood flow to the brain).<br><br>The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required extensive assistance with bathing, dressing and personal hygiene. The resident did not have any behaviors or rejection of care.<br><br>B. Resident and resident representative interview<br><br>Resident #52 was interviewed on [DATE] at 2:30 p.m. Resident #52 said she was very nervous and worried about speaking to anyone because she was worried what she said would be used against her. Resident #52 said the nursing home administrator (NHA) once told her she was a mandated reporter. The resident said she was worried that meant the NHA would use her status as a mandated reporter to stop her sister from being her legal representative and also stop her sister from visiting me if she said too much or complained.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #52 said one night last month ([DATE]), she woke up and her room was very cold. Resident #52 said she asked one of the certified nurse aides (CNA) to adjust the heat and the CNA would not adjust the heat and instead piled a bunch of blankets on top of her. The CNA then told her that was good enough. Resident #52 said she complained to the facility staff about the encounter and the social services director (SSD) came to her room to talk to her about her complaint. Resident #52 said after she spoke to the SSD, the previous director of nursing (DON) came to talk to her about her grievance but did not explain how they planned to resolve the staff's refusal to honor a request like turning the heat up a couple of degrees. She said after the DON spoke to her, the NHA came to her room and told her the matter had been resolved but did not tell her how it was resolved.<br><br>Resident #52 said after she voiced her grievance about the CNA's response to her request to turn up her heat, facility leadership responded by imposing care in pairs, which meant that any time a staff member came to her room there needed to be two staff present to provide any assistance so the staff had a witness for the interactions. Resident #52 said she worried that the staff would stick together and no one would believe anything she said. Resident #52 said she wanted a witness for herself. Resident #52 said that was the reason she did not want to discuss care issues or make medical decisions without her legally designated representative being present. Resident #52 said the facility's response to her grievance was upsetting and made her very anxious. She said if staff were to come in to discuss concerns with her and ask her to make decisions about her daily care she wanted her legal representative to be present.<br><br>Resident #52 said the facility's leadership staff was bossy. The resident said she brought things to the facility's attention and the staff did not listen to everything she had to say. She said the leadership staff would end the conversations by saying That is all I am going to say. Resident #52 said she did not feel listened to.<br><br>The resident's representative was interviewed on [DATE] at 2:30 p.m. The resident's representative said she and Resident #52 had voiced several grievances to facility staff on numerous occasions. She said most of the time the grievances were verbally communicated and the facility failed to provide a written response of actions taken to resolve the concerns. The resident's representative said most of the time she tried to talk to facility leadership privately about their concerns because talking about the grievances in front of Resident #52 was upsetting to the resident and made Resident #52 very anxious.<br><br>The resident's representative said she filed a records request for the grievance action reports filed by her and Resident #52 and some other medical records information on [DATE] but had yet to receive the responses (cross-reference F573 for failure to provide residents the right to access/ purchase copies of records).<br><br>The resident's representative said she and Resident #52 did not feel their grievances were resolved fully or to their satisfaction. She said the facility kept changing the way they resolved their concerns and she and Resident #52 wanted the facility's resolutions provided in writing.<br><br>C. Record review<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #52's grievance report dated [DATE] documented Resident #52 voiced a concern regarding the temperature of her room on the night of [DATE]. The concern form documented Resident #52 said she activated her call light and requested the CNA to turn the heat up to 75 degrees when she noticed the heat had been turned down to 73 degrees and she was freezing. The resident requested the CNA to turn up the heat.<br><br>The grievance form documented the resident reported the CNA refused to turn up the heat and said she was unable to access the heater controls. The CNA got the resident extra blankets. The resident said she was unable to go back to sleep. The resident said she did not want extra blankets but instead wanted the heat turned up and she needed assistance from staff to reach and access the heater controls.<br><br>The grievance form documented the action taken by the facility to ask the resident if she got someone who could help her and the resident said yes.<br><br>-However, per Resident #52, the staff who came to help the resident refused to honor her request.<br><br>The grievance form documented that the facility interviewed the CNA who responded to Resident #52's call light on the night she requested her heat be turned up; the CNA said she provided the resident blankets and did not adjust the heat as providing the resident with blankets would be the same as the turning the heat up. The CNA said after the staff left the room, the resident screamed for the heat to be fixed. The CNA said she explained to the resident that screaming was disruptive and Resident #52 said she did not care. The CNA said she asked Resident #52 not to speak to her that way.<br><br>-The grievance report documented how the CNA made a decision to disregard the resident's request and implemented her own solution rather than work with the resident to come up with an agreeable solution. Additionally, the report failed to document how the facility planned to ensure that the resident's request would be accommodated in the future, or if it was not possible to accommodate the resident's request, how the staff would work with the resident to come up with an agreeable resolution.<br><br>-According to the grievance report, the resident did not agree with the resolution and declined to sign the finalized report.<br><br>The [DATE] grievance form submitted by Resident #52 revealed the resident was concerned because she signed a medical records release form on [DATE] and had received a menu instead. The resident was told she had to submit a new medical records release form. The facility's response on the form documented the facility had 30 days to get the information to the resident. The resident and her representative said the information was supposed to be provided within two days. The form documented the concern would be addressed with the NHA. The follow-up action documented an email was sent by medical records confirming the records were sent.<br><br>-However, the response did not document the date the records were sent to the resident and the resident's representative.<br><br>The form documented the resolution was reviewed verbally with the resident's legal representative and was resolved on [DATE].<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -However, the resident and her representative did not feel the concern had been addressed because they had not received the medical records.<br><br>III. Staff interviews<br><br>The social services director (SSD) was interviewed on [DATE] at 12:16 p.m. The SSD said he was the grievance officer and managed grievances and complaints. The SSD said staff were asked to complete a grievance form when a resident voiced a concern. The SSD said, as the grievance officer, he would check and pick up all concern forms from the hallway grievance box a couple of times a day. The SSD said he also received written grievance forms directly from staff and residents. He said once a grievance form was accepted, he handed it over to the manager responsible for the area related to the concern for them to investigate and issue a resolution. He said the manager had 72 hours to respond to a resident's grievance and get the form back to the resident to see if they agreed to the resolution.<br><br>The SSD said if the resident agreed and it was fully resolved, the grievance was filed in the facility's grievance binder. He said if the resident did not agree and the concern was not resolved, the grievance was turned back to the program manager to attempt another resolution. He said the grievances that came in over the weekend should be reported directly to a member of the leadership team in case it required urgent attention.<br><br>The SSD said food grievances were directed to the DM. He said the facility had a lot of concerns with room trays and the facility was looking into those concerns and addressing the identified issues with leadership and the food committee monthly.<br><br>The SSD said he was trending grievance concerns and it was rare to receive a concern about long call lights but most nursing related complaints were about agency staff not knowing residents' care. The facility had a few grievances about missing items that were usually located after a search.<br><br>The SSD said the facility was usually able to resolve concerns quickly and when concerns were not resolved, they made a call to the ombudsman to see if the ombudsman could speak with the resident to see if they could assist with a resolution as a neutral person.<br><br>The NHA was interviewed on [DATE] at 1:10 p.m. The NHA said she had many discussions with Resident #52 and her representative and had tried to resolve their concerns. The NHA said the facility had made several adjustments in the residents' care to try to meet the resident's and the resident representatives' requests but the resident's representative still had unresolved concerns that the facility continued to address.<br><br>The NHA said with regard to the heater incident, the facility staff did not adjust the heat as the resident requested because the heat was already reading in the 70's and the staff did not think it needed to be turned up higher. The NHA considered that the grievance was resolved. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960<br><br>Based on observation, record review and interviews, the facility failed to ensure one (#13) of one resident reviewed out of 33 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities.<br><br>Specifically, the facility failed to:<br><br>-Ensure Resident #13 was assisted and encouraged to shower and maintain personal hygiene; and,<br><br>-Ensure Resident #13's care plan addressed his refusals of showers and provided person-centered interventions to ensure the resident had appropriate hygiene.<br><br>Findings include:<br><br>I. Facility Policy<br><br>The Bath, Shower/Tub policy and procedure, revised February 2018, was provided by the director of clinical services (DCS) on 4/24/24 at 5:13 p.m. It read in pertinent part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.<br><br>Notify the supervisor if the resident refuses the shower/tub bath.<br><br>II. Resident #13<br><br>Resident #13, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included schizophrenia (a disorder that affects a person's ability to think and act clearly), type II diabetes mellitus, obsessive-compulsive disorder (unwanted thoughts and fears) and morbid obesity.<br><br>The 4/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment identified the resident needed partial to moderate assistance with toilet hygiene and dressing and was independent with personal hygiene.<br><br>The MDS assessment indicated the resident refused to shower or bathe during the assessment.<br><br>III. Resident #13 interview<br><br>Resident #13 was interviewed on 4/21/24 at 10:27 a.m. Resident #13 said he had not had a shower in over two weeks. He apologized multiple times for being disheveled and smelly. Resident #13 said he wanted a shower but he understood that things happened and he could not always get a shower when he wanted one.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #13 was interviewed again on 4/23/24 at 10:55 a.m. He said he preferred to have a male CNA assist him with showers. He said he had a fear of falling in the shower and preferred to have assistance. He said the male CNA that he preferred to have help him shower was not at the facility today. He said there was an agency CNA working instead. He said the agency CNA did not know him and he did not think he could trust her to keep him from falling so he did not want to get a shower today.<br><br>IV. Observations<br><br>On 4/21/24 at 10:27 a.m. Resident #13 was sitting on a bench across from the nurses station. The resident was wearing blue sweatpants, smelled strongly of urine and his scalp was dry and scaley.<br><br>On 4/22/24 at 10:04 a.m. Resident #13 was sitting on a bench across from the nurses station. The resident was wearing the same blue sweatpants, smelled strongly of urine and his scalp was dry and scaley.<br><br>On 4/23/24 at 10:55 a.m. Resident #13 was sitting on a bench across from the nurses station. Resident #13 was wearing the same blue sweatpants, smelled strongly of urine and body odor and had visibly dirty and matted facial hair.<br><br>At 11:04 a.m. Resident #13 was observed in a conversation with the social services assistant (SSA). Resident #13 said he wanted to take a shower but he did not know when the certified nurse aide (CNA) that he trusted would be back to work. The resident told the SSA he was concerned of being sued by female CNAs if he allowed one of them to assist him in the shower (see SSA interview below). The SSA encouraged Resident #13 to continue to wait for a shower so he would be comfortable.<br><br>On 4/23/24 at 11:12 a.m. Resident #13 was sitting on a bench across from the nurses station. Resident #13 was talking to another resident about how he wanted a shower and needed to shave his facial hair. Resident #13 said he knew he was not clean and needed a shower and other personal hygiene but he was not going to get anxious about it.<br><br>V. Record review<br><br>The activities of daily living (ADL) care plan, initiated on 4/29/14 and revised on 6/20/23, revealed Resident #13 had a self-care performance deficit related to weakness, impaired balance and activity intolerance. The interventions included providing the resident a shower on Sundays and providing the resident towels and washcloths when he frequently declined showers so he could wash himself at his bathroom sink.<br><br>-A review of Resident #13's comprehensive care plan did not reveal person-centered interventions, such as consistent male caregivers, to encourage Resident #13 to shower and receive personal hygiene regularly.<br><br>Resident #13's bathing record from 3/27/24 to 4/24/24 revealed the resident had refused showers on 3/27/24, 4/3/24, 4/10/24 and 4/17/24.<br><br>-A review of Resident #13's shower records revealed the resident had not received a shower in at least 30 days.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A review of the resident's medical record did not reveal the resident was reapproached or person-centered interventions were implemented to encourage Resident #13 to take a shower.<br><br>VI. Staff interviews<br><br>The SSA was interviewed on 4/23/24 at 11:10 a.m. The SSA said Resident #13 needed a shower. The SSA said he was aware Resident #13 had a preference for who he would allow to assist him in the shower. He said he did not know if that CNA was still employed at the facility and if he was on the schedule anytime soon. He said Resident #13 was embarrassed about staff seeing his body and was worried about female staff being alone with him and suing him. The SSA said he would look into what needed to happen for the resident to get a shower.<br><br>The director of nursing (DON) and assistant director of nursing (ADON) were interviewed together on 4/23/24 at 2:45 p.m. The DON said Resident #13 had paranoia around females assisting him with a shower. The DON said the male CNA who was often able to assist Resident #13 in the shower per Resident #13's preference had called out sick and was going on leave so the resident would likely continue to refuse to shower.<br><br>The ADON said Resident #13 had been offered wet wipes and would sometimes clean himself in his room.<br><br>The DON said staff offered to help Resident #13 change his clothes, offered to have two staff members to assist with showers and offered to keep him partially covered in the shower but the resident continued to refuse.<br><br>-However, review of the resident's medical record did not reveal these interventions had been attempted.<br><br>The DON said she had told Resident #13 he had body odor and needed a shower. The DON said she had no idea what else the facility could do to get Resident #13 to take a shower. The DON said she felt the facility had tried everything.<br><br>The medical director (MD) was interviewed on 4/24/24 at 10:11 a.m. The MD said Resident #13 had negative effects from years of poorly treated schizophrenia and it presented in his hygiene habits. The MD said he had a good relationship with Resident #13 and he needed to have a conversation with the resident regarding personal hygiene. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315<br><br>Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (#3) of five residents reviewed for ADL care assistance out of 33 sample residents.<br><br>Specifically, the facility failed to assist and provide Resident #3 with her scheduled showers and wash her hair with the prescribed medicated shampoo.<br><br>Findings include:<br><br>A. Facility policy<br><br>The Activities of Daily Living policy, revised March 2018, was received by the corporate director of clinical services (CDCS) on 4/24/24 at 5:13 p.m. The policy documented in pertinent part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene.<br><br>B. Resident status<br><br>Resident #3, age 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis (disease disabling the brain and spinal cord), dementia and functional quadriplegia (complete immobility from physical disability).<br><br>The 3/27/24 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive assistance for transfers, toilet use, personal hygiene and bathing. The resident did not reject care.<br><br>C. Resident interview<br><br>Resident #3 was interviewed on 4/22/24 at 2:24 p.m. Resident #3 said she had not gotten a shower more than once a week for the past several weeks. She said she preferred taking two showers a week and the staff were too busy to give her more than one shower a week. She said this bothered her and her scalp got itchy. She said she got frustrated when she did not get the help she needed because she was dependent on staff for assistance.<br><br>Resident #3 said she never refused showers when offered. She said she often felt dirty and did not want her skin to break down. She pointed out a bottle of [NAME] shampoo and [NAME] conditioner and said that was what the certified nurse aides (CNA) used to wash her hair when she received a shower. She said she did not go to the hair salon on a scheduled basis to get her hair washed anywhere else.<br><br>During the interview Resident #3, was observed scratching her head every couple minutes. Her hair was messy, out of place and greasy.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | D. Record review<br><br>According to the April 2024 CPO, Resident #3 had a physician's order to wash her hair with Selsun Blue Dry Scalp shampoo every Wednesday and Sunday, start date 1/24/24.<br><br>-However, CNA #7, who said she showered the resident the most, said they used the pink shampoo from the resident's room during her showers and was not aware that the resident had an order for a medicated shampoo (see CNA #7's interview below).<br><br>Review of Resident #3's record for the ADL task of bathing from 3/27/24 to 4/20/24 revealed Resident #3 received five showers (3/27/24, 4/3/24, 4/10/24, 4/17/24 and 4/20/24) out of eight shower opportunities during that timeframe.<br><br>The bathing record documented Resident #3 refused her shower on 4/6/24 and 4/13/24.<br><br>-However, the resident said she never refused staff offers to give her a shower (see resident interview above).<br><br>-Additionally, 4/6/24 and 4/13/24 were Saturdays, not Sundays (see physician's order above).<br><br>The bathing record documented the bathing task was not applicable on 3/30/24 (a Saturday, not a Sunday).<br><br>-There was no further documentation for showers on the bathing record from 3/27/24 to 4/20/24.<br><br>D. Staff interviews<br><br>CNA #7 was interviewed on 4/29/24 at 3:02 p.m. CNA #7 said she had given Resident #3 several showers in the past two months and used the pink shampoo and conditioner that the resident purchased and kept in her room. CNA #7 pointed out the pink shampoo and conditioner in the clear bottles in the resident's room during the interview. She said she had never used a blue bottle of shampoo for Resident #3 or obtained a special shampoo from the nursing medication cart.<br><br>CNA #7 said the resident was cooperative with showers and did not refuse care. She said in the charting system, the option for not applicable meant the staff did not have time to get the task completed.<br><br>CNA #7 pointed out the CNA shower book and said Resident #3 was scheduled for showers on Wednesdays and Saturdays.<br><br>-However, according to the physician's order dated 1/24/24, Resident #3 was to have her hair washed with the medicated shampoo on Wednesdays and Sundays.<br><br>Registered Nurse (RN) #5 was interviewed on 4/24/24 at 2:30 p.m. RN #5 said Resident #3 did not refuse care, which included showering. RN #5 said in addition to assisting Resident #3 with showering, the CNAs were supposed to wash the resident's hair with the prescribed Selsun Blue Dry Scalp shampoo which they were supposed to get from the nurse.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The director of nursing (DON), the nursing home administrator (NHA) and the CDCS were interviewed on 4/24/24 at 11:14 a.m. The DON said if a shower was refused by a resident, the nursing staff was to reapproach the resident later that same shift. If the resident continued to refuse the shower, the nursing staff were to get the charge nurse involved. The charge nurse was to educate the resident on showering, encourage the shower, and include it in the care plan. She said the nursing staff would document the refusal in the resident's chart.<br><br>-The progress notes and care plan were reviewed and there was no documentation that the resident ever refused showering assistance. There was nothing documented in the care plan that the resident refused showers and no interventions for what to do if the resident were to refuse showering assistance. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315<br><br>Based on observations, record review and interviews, the facility failed to ensure a resident receiving enteral feeding (nutrition delivered directly to the stomach or intestinal tract) received appropriate care and services to prevent complications of enteral feeding for one (#49) of one resident out of 33 sample residents.<br><br>Specifically, the facility failed to:<br><br>-Administer Resident #49's medications per professional standards by properly liquifying the medication. administering each medication separately with adequate water flushes between medications in order to prevent clogging of the resident's gastric tube; and,<br><br>-Check gastric residual (amount of undigested feeding left in the stomach) prior to starting Resident #49's enteral gastric tube feeding per physician's orders.<br><br>Findings include:<br><br>I. Professional reference<br><br>According to the National Library of Medicine National Center for Biotechnology Information, [NAME], E.K., Open Resources for Nursing Skills Administration of Enteral Medications, 2021, retrieved on 4/30/24 from https://www.ncbi.nlm.nih.gov/books/NBK593215/,<br><br>Medication is administered via an enteral tube when the patient is unable to orally swallow medication. Medications given through an enteral feeding tube should be in liquid form whenever possible to avoid clogging the tube. If a liquid form is not available, medications that are safe to crush should be crushed finely and dissolved in water to keep the tube from becoming clogged.<br><br>Prior to medication administration, verify tube placement. Placement is initially verified immediately after the tube is placed with an X-ray, and the nurse should verify these results. Additionally, bedside placement is verified by the nurse before every medication pass. There are multiple evidence-based methods used to check placement. One method includes aspirating tube contents with a 60-mL (milliliter) syringe and observing the fluid. Fasting gastric secretions appear grassy-green, brown, or clear and colorless, whereas secretions from a tube that has perforated the pleural space typically have a pale yellow serous appearance . Note that installation of air into the tube while listening over the stomach with a stethoscope is no longer considered a safe method to check tube placement according to evidence-based practices.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | After tube placement is checked, a clean 60-mL syringe is used to flush the tube with a minimum of 15 mL of water (5-10 mL for children) before administering the medication. Follow agency policy regarding flushing amount. Liquid medication, or appropriately crushed medication dissolved in water, is administered one medication at a time. Medication should not be mixed because of the risks of physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses. Between each medication, the tube is flushed with 15 mL of water, keeping in mind the patient's fluid volume status. After the final medication is administered, the tube is flushed with 15 mL of water. The tube is then clamped, or if the patient is receiving tube feeding, it can be restarted.<br><br>II. Facility policy and procedure<br><br>The Medication Administration policy and procedure, revised 2/29/24, was provided by the nursing home administrator (NHA) on 4/24/24 at 5:13 p.m. It read in pertinent part,<br><br>Resident medications are administered in an accurate, safe, timely and sanitary manner.<br><br>The Tube Feeding policy and procedure, revised 2/23/24, was provided by the corporate director of clinical services (CDCS) on 4/24/24 at 5:13 p.m. It read in pertinent part,<br><br>Review the resident's care plan and provide any special needs of the resident. Verify placement of tube per current professional standards.<br><br>III. Resident #49<br><br>A. Resident Status<br><br>Resident #49, age under 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnosis included autism disorder, dysphagia (swallowing difficulties) and chronic respiratory failure.<br><br>The 2/21/24 minimum data set (MDS) assessment revealed the resident had severely impaired cognition with a brief interview for mental status (BIMS) score of three out of 15. The resident required extensive assistance for transfers, toilet use, personal hygiene and bathing. The resident did not reject care.<br><br>B. Observation<br><br>On 4/22/24 at 10:51 a.m., registered nurse (RN) #3 was observed administering medications to Resident #49. RN #3 prepared the medications first by crushing the oral tablets and measuring the liquid medications.<br><br>After preparing the medications, RN #3 entered Resident #49's room and checked the gastric tube placement by inserting 60 milliliters (ml) of air into the tube with a syringe and listening to the resident's abdomen with her stethoscope.<br><br>After ensuring the gastric tube was in place, RN #3 flushed the tube with 60 ml of water with a syringe. RN #3 proceeded to administer each liquid medication into the tube through the syringe.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -RN #3 failed to flush the tube with water in between each liquid medication.<br><br>-RN #3 proceeded to insert one crushed dry medication tablet with the syringe. She attempted to let the dry medication go down the gastric tube before inserting 10 ml of water into the tube with the syringe. RN #3 proceeded to repeat the same procedure with the second crushed dry medication tablet.<br><br>-RN #3 failed to dissolve each crushed medication in water prior to administering the medications through the gastric tube.<br><br>-RN #3 failed to flush the gastric tube with an appropriate amount of water between the medications.<br><br>After struggling to get the previous two dry medications passed though the gastric tube, RN #3 mixed the next crushed dry medication tablet with approximately 10 ml of water and administered the medication through the syringe into the tube. She administered the last medication through the syringe into the tube and flushed the tube with approximately 20 ml of water.<br><br>-RN #3 failed to administer a water flush between the last two medications she administered.<br><br>On 4/22/24 at 11:00 a.m., RN #3 prepared to initiate a tube feeding for Resident #49. She confirmed the tube feeding matched the order. She turned on the pump and confirmed the feeding rate and water flush rate matched the order. She connected the tube feeding to the resident's feeding tube and started the feeding.<br><br>-RN #3 did not check for gastric residual prior to starting the tube feeding, per the physician's order.<br><br>C. Record review<br><br>The April 2024 CPO included the following physician's orders:<br><br>Check and record residual prior to enteral feeding, start date 3/29/24.<br><br>Flush gastric tube with 60 ml of water before and after medication administration, four times daily, start date 11/29/22.<br><br>The comprehensive care plan, revised 9/12/23, revealed Resident #49 was receiving tube feeding. Interventions included checking for tube placement and gastric contents/residual volume and recording and holding feeding if the residual was greater than 100 ml.<br><br>C. Staff Interview<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The director of nursing (DON), the NHA, and the CDCS were interviewed on 4/24/24 at 11:14 a.m. The DON said prior to administering medication or enteral feeding through a feeding tube, the nurse should always check for gastric residual. The DON said this step was important to confirm the feeding and medications were getting digested properly. She said while administering crushed medications through a feeding tube, each medication should be premixed with 30 ml of water and administered separately. She said this was important to ensure the feeding tube did not have a risk of getting clogged with medication. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47422<br><br>Based on observations, record review and interviews, the facility failed to ensure one (#16) of two residents reviewed for pain out of 33 sample residents had an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans and resident preferences.<br><br>Specifically, the facility failed to ensure Resident #16 was offered effective pain management to include non-pharmacological interventions.<br><br>Findings include:<br><br>I. Facility policy<br><br>The Pain Management policy, revised 5/3/23, was provided by corporate consultant (CC) #1 on 4/24/24 at 5:13 p.m. It read in pertinent part,<br><br>Pain is subjective and is what the resident says it is, existing when and where the resident says it does. The pain evaluation will be completed upon admission, readmission, quarterly, and with any significant change in condition.<br><br>The pain evaluation includes the following: location(s), quality, intensity, associated symptoms, precipitating, aggravating and relieving factors, chronology, pattern (frequency, onset and duration of pain), medication regimen and other treatment modalities used for pain management and their degree of effectiveness.<br><br>All subsequent pain evaluations will be documented on the Pain Evaluation in the medical record system and/or the medication administration record (MAR) as applicable to, to include location, intensity rating, and response to pain management interventions.<br><br>When a resident complains of pain, ask the resident to rate the level of pain using the Numerical Scale using a pain level of zero (none) to ten (severe). Around the clock (ATC) dosing for continuous pain, whether it be chronic or acute, is the key to effective pain management.<br><br>Do not forget the non pharmacological interventions such as repositioning, relaxation, aromatherapy, visualization, desensitization, massage, and humor therapy. Non-pharmacological interventions should be documented in progress notes and included on the individual resident care plan.<br><br>II. Resident #16<br><br>A. Resident status<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #16, age 74, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included ataxic cerebral palsy (a developmental disorder that affects muscle movement and control), type 1 diabetes mellitus with diabetic polyneuropathy (a complication of diabetes that affects the nerves that branch out from the spinal cord into the legs, arms, hands, and feet), chronic pain syndrome and radiculopathy (multiple pinched nerves).<br><br>The 2/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. The resident was dependent on staff for showering. He was independent with eating, oral hygiene, toileting, upper body dressing and personal hygiene.<br><br>The MDS assessment indicated the resident received scheduled pain medications. The resident did not receive as needed pain medications or non-medications interventions for pain. The resident frequently had pain that occasionally affected his sleep. The resident reported a pain level of 8 on a pain scale of 1 - 10.<br><br>B. Resident interview and observations<br><br>Resident #16 was interviewed on 4/22/24 at 11:07 a.m. Resident #16 said due to his medical conditions he was constantly in pain. He said after the licensed nursing staff assessed his pain he did not feel they provided adequate interventions to address his pain level. He said he only received scheduled Tylenol to alleviate his pain.<br><br>Resident #16 said the facility did not offer him non-pharmacological interventions when he reported pain. He said that due to the pain being a chronic condition he felt the facility did not take his pain seriously sometimes. He said since he was in recovery from alcoholism he was limited on what medication he could take but said that he would accept any treatment the facility had to offer him to alleviate his pain symptoms.<br><br>C. Record review<br><br>The acute and chronic pain care plan, initiated 2/11/19 and revised 2/19/21, revealed Resident #16 had pain related to his diagnosis of depression, neurological impairment, chronic neck and back pain, cerebral palsy and diabetes. The interventions included, notifying the physician if interventions were unsuccessful or if the current complaint was a significant change from residents past experience of pain, reporting change in usual activity attendance patterns or refusal to attend activities related to signs and symptoms or complaints of pain or discomfort and offering non-pharmacological interventions for pain (offering a snack, drink, redirecting, offering an activity or actively supplies, offering to call a loved one, offering to sit outside, offering to sit with the resident as needed, offering a shower or bath, provide active listening and validation, offering range of motion exercises, massage, relaxation and breathing techniques, imagery and distraction techniques, re-positioning, aromatherapy and therapeutic touch and massage).<br><br>-A review of the resident' s electronic medical record (EMR) did not reveal documentation of person-centered non-pharmacological pain interventions or documentation that non-pharmacological pain interventions were attempted.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the resident' s EMR revealed Resident #16' s pain level was assessed eight times from 4/22/24 at 6:29 a.m. through 4/23/24 at 11:40 a.m. Resident #16 reported his pain level at a 9, four times. Resident #16 reported his pain level at a 10, two times.<br><br>-A review of the resident' s EMR did not reveal documentation that non-pharmacological pain interventions were offered to the resident when he reported his pain level at a 9 or a 10 from 4/22/24 to 4/23/24.<br><br>The resident had a physician' s order to receive 650 milligram (mg) of acetaminophen by mouth three times a day for neuropathy pain not to exceed 3000 mg, ordered on 6/17/21.<br><br>D. Staff interviews<br><br>The medical director (MD) was interviewed on 4/24/24 at 9:53 a.m. The MD said residents with certain types of pain, including neuropathy, needed more than just medications. He said it was important to look for a root cause and offer the resident other solutions that were not just medications. He said this included non-pharmacological interventions that were effective for resident specific pain management.<br><br>Certified nurse aide (CNA) #9 was interviewed on 4/24/24 at 11:05 a.m. CNA #9 said when a resident expressed they were in pain she reported it to the licensed nurse on duty. She said she attended meetings on Mondays, Wednesday and Fridays to discuss residents who had pain. She said she did not recall discussing Resident #16 in the meeting. She said she listened to the residents' complaints of pain to help determine the root cause.<br><br>Registered nurse (RN) #5 was interviewed on 4/24/24 at 11:11 a.m. RN #5 said non-pharmacological interventions were effective for residents that were outside their medication administration window. She said all non-pharmacological interventions were documented in a nursing progress note when administered. She said staff needed to follow up with the physician when pain could not be managed for further recommendations and orders.<br><br>The director of nursing (DON) was interviewed on 4/24/24 at 11:22 a.m. The DON said Resident #16 had no physical signs of pain when he reported pain to the staff so it was hard to take his pain seriously. She said his pain was chronic and nothing had helped to change it. She said the facility offered the resident non-pharmacological interventions in the past but he declined them. She said the facility had not offered any non-pharmacological interventions recently. She said any non-pharmacological interventions were documented in the resident' s progress notes. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50315<br><br>Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored according to professional standards in one of three medication carts, one of two medication treatment carts and one of two medication rooms.<br><br>Specifically, the facility failed to ensure medication rooms and medication/treatment carts were locked properly when unattended by a licensed nurse.<br><br>Findings include:<br><br>I. Facility Policy<br><br>The Storage of Medication policy, revised November 2020, was received from the corporate director of clinical services (CDCS) on 4/24/24 at 5:13 p.m. It documented in pertinent part,<br><br>Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Only persons authorized to prepare and administer medications have access to locked medications. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.<br><br>II. Observations<br><br>On 4/21/24 at 9:10 a.m. the medication room on the Aspen hallway was unlocked.<br><br>-The room contained prescription medications for multiple residents and the medication nurse did not maintain direct line of sight to monitor the resident medications.<br><br>Additionally, a treatment cart, which contained medicated treatment supplies, was next to the medication room and was unlocked.<br><br>-The treatment cart was not in direct line of sight from the licensed nurse responsible for the cart's contents.<br><br>On 4/22/24, medication pass was performed on the Aspen hall by registered nurse (RN) #3. The following was observed:<br><br>-At 10:03 a.m., RN #3 left the medication cart, which contained several medications for multiple residents, unlocked and unmonitored, to go check on a resident in their room. The cart was left in the hall without supervision from the licensed nurse responsible for the cart's contents. The RN came back to the cart at 10:04 a.m.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At 10:20 a.m., RN #3 walked away from the medicion cart to deliver a nutritional shake to a resident down the hall. Prior to walking away from the medication cart, RN #3 pushed the cart's locking mechanism to lock the cart.<br><br>However, two of the drawers to the medication cart were not closed all the way when the cart was locked, leaving them unlocked and accessible to anyone walking by the medication cart. The drawers contained prescription medication and medical supplies.<br><br>-RN #3 did not return to the cart until 10:25 a.m. (five minutes after initially leaving the medication cart unattended and improperly locked).<br><br>-RN #3 left the cart and returned to it two more times. Each time she left the cart she closed the push lock mechanism but did not ensure the drawers were fully closed and secured.<br><br>-Despite locking the push lock the drawer was easy to open and the medications inside were accessible.<br><br>On 4/23/24 at 12:57 p.m. the Aspen hall medication cart, which contained several resident prescription medication cards for residents, was outside the dining room without supervision from the licensed nurse responsible for the cart's contents. The cart's locking mechanism had been engaged, however, there were a couple of drawers that had not been closed completely when the cart was locked and were accessible to residents and staff.<br><br>-At 1:02 p.m. the director of nursing (DON) was notified that the medication cart was unlocked and the drawers could not be secured without the key to unlock the locking mechanism and fully close the open drawers. The DON arrived on the unit and tried to lock the cart but was unable. The DON walked down the hall and retried with RN #3 at 1:03 p.m. to reset the locking mechanism so the open drawers could be re-engaged and locked.<br><br>III. Interviews<br><br>The DON, the nursing home administrator (NHA) and the CDCS were interviewed on 4/24/24 at 11:14 a.m. The DON said medication rooms, medication carts and medication treatment carts containing medications were to be closed and locked properly when the licensed nurse in charge of the carts and resident medications was not in direct line of sight of the medication/treatment cart or the medication room. The DON said it was important to ensure medication/treatment carts and medication rooms were locked because only licensed nurses should have access to medications. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>47422<br><br>Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures.<br><br>Specifically, the facility failed to ensure resident food was palatable in taste, temperature and texture.<br><br>Findings include:<br><br>I. Resident interviews<br><br>Resident #35 was interviewed on 4/21/24 10:20 a m. Resident #35 said the food was either served cold or was bland and unseasoned which made it taste terrible.<br><br>Resident #20 was interviewed on 4/21/24 at 10:46 a.m. The resident said the food was just okay and was often served cold.<br><br>Resident #209 was interviewed on 4/21/24 at 10:54 a.m. Resident #209 said the food was terrible because it was almost always served cold. She said because the food was served cold it did not taste good (cross-reference F585 for failure to respond to grievances).<br><br>The family representative for Resident #56 was interviewed on 4/21/24 at 2:33 p.m. The representative said Resident #56 did not like a lot of the food prepared by the facility and was unable to say she did not like the food she was being served. When the resident was served foods she did not like she would stop eating. If the resident did not like the food she was served the staff would not always offer her something else to eat. The representative said since she knew what kinds of foods the resident liked she tried to come in every other day and order Resident #56' s meals in advance. She said it was hard when agency staff who did not know the resident well tried to feed her.<br><br>II. Observations<br><br>On 4/21/24 at 11:30 a.m. meal service was observed several residents only ate half or less of their meal and no staff inquired about why the resident(s) were not eating nor did they offer the residents an alternative meal choice.<br><br>On 4/23/24 at 12:29 p.m. a test tray for a regular diet was evaluated by five surveyors immediately after the last resident had been served their room tray for lunch<br><br>The test tray consisted of seafood alfredo, garlic bread, green beans and spice cake with icing:<br><br>-The shrimp in the seafood alfredo was mushy and had a strong flavor of fish;<br><br>-The noodles in the seafood alfredo were tough and chewy;<br><br>-The green beans were waxy, flavorless and chewy; and,<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The iced spice cake was dry.<br><br>III. Record review<br><br>A request was made for the food committee notes on 4/24/24. The food committee notes were not received during the survey process.<br><br>IV. Staff interviews<br><br>The dietary manager (DM) was interviewed on 4/24/24 at 1:29 p.m. The DM said the food committee met once a month to go over concerns the residents had regarding the food. She said the facility used a new distributor for food and had never bought the shrimp that was served on the test tray before. She said, due to budget constraints, it was difficult to accommodate all the requests from the residents but she did the best she could.<br><br>The DM said she had noticed in the past that food tray delivery took a long time and she was working with the facility administrator to find a solution. She said residents had complained that the noodles served in the facility were chewy and unappetizing multiple times in the past. She said when any concerns were raised at the food committee meetings, the facility would do the best they could best to accommodate the requests. She said the residents were encouraged to order off of the ala carte menu that included items such as burritos, pizza and hamburgers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>47960<br><br>Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection at the facility.<br><br>Specifically, the facility failed to;<br><br>-Ensure housekeeping staff followed the proper cleaning techniques for cleaning resident rooms and disinfecting high frequency touched areas (light switches and door handles);<br><br>-Ensure housekeeping staff performed hand hygiene when appropriate;<br><br>-Clean the mechanical lift and vitals machine between each use with a resident;<br><br>-Perform hand hygiene during medication administration;<br><br>-Offer hand hygiene to each resident before meals; and,<br><br>-Perform hand hygiene between each resident when assisting with meals.<br><br>Finding include:<br><br>I. Housekeeping practices and disinfection of environmental surfaces<br><br>A. Professional reference<br><br>Assadian O, Harbarth S, Vos M, et al. Practical recommendations for routine cleaning and disinfection procedures in healthcare institutions: a narrative review. The Journal of Hospital Infection. (2021 Jul);113:104-114 was retrieved on 4/30/24 from https://pubmed.ncbi.nlm.nih.gov/33744383/ revealed, in pertinent part:<br><br>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The Centers for Disease Control (CDC) Environment Cleaning Procedures (5/4/23) was retrieved on 4/30/24 from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html# It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.<br><br>Common high-touch surfaces include:<br><br>-bedrails<br><br>-IV (intravenous) poles<br><br>-sink handles<br><br>-bedside tables<br><br>-counters<br><br>-edges of privacy curtains<br><br>-patient monitoring equipment (keyboards, control panels)<br><br>-call bells<br><br>-door knobs.<br><br>According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 4/30/24 from https://www.cdc.gov/handhygiene/providers/index.html, Cleaning your hands reduces the spread of potentially deadly germs to patients.<br><br>Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.<br><br>Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations.<br><br>Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.<br><br>When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.<br><br>Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin.<br><br>B. Facility policy and procedure<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The Cleaning and Disinfecting Resident Rooms policy and procedure, revised August 2013, was provided by the clinical consultant (CC) on 4/24/24 at 5:13 p.m. It read in pertinent part, Clean all high-touch personal use items (lights, phones, call bells, bedrails) with disinfectant solution. Perform hand hygiene after removing gloves.<br><br>C. Observations<br><br>On 4/22/24, during a continuous observation beginning at 2:00 p.m. and ending at 2:24 p.m., housekeeper (HK) #1 was observed cleaning a room on the east unit. HK #1 put on gloves before entering the room.<br><br>HK #1 sprayed the bathroom sink, toilet, and handrail with the disinfectant spray. HK #1 exited the bathroom and sprayed the drawer pulls, remotes for the bed and television (TV) and the bedside table.<br><br>After four minutes, HK #1 began wiping the drawer pulls, remotes, bedside table, nightstand and refrigerator. She proceeded to remove the trash bag from the receptacle near the resident's bed and put new bags in the trash can.<br><br>-HK #1 failed to disinfect high touch areas such as the light switches and the door handles in the room.<br><br>HK #1 removed her gloves, took a pen out of the drawer and wrote the temperature of the refrigerator on the log on the door of the refrigerator.<br><br>HK #1 put new gloves on, sprayed the bathroom with disinfectant spray again and began wiping down the sink, the grab bar, the top of the toilet and the shelf.<br><br>-HK #1 did not perform hand hygiene prior to putting on the new pair of gloves.<br><br>HK #1 proceeded to clean the inside of the toilet, the sink and wiped the toilet seat last.<br><br>-HK #1 failed to clean the toilet in a sanitary manner by wiping the toilet seat after she had cleaned the inside of the toilet.<br><br>HK #1 exited the bathroom and swept the entire floor.<br><br>-HK #1 failed to change her gloves and perform hand hygiene prior to using the broom to sweep the resident's floor.<br><br>HK #1 mopped the living area and the bathroom floor before exiting the room.<br><br>-At 2:24 p.m. HK #1 entered the next resident's room, went to the sink in the resident's bathroom and washed her hands for six seconds using soap and water.<br><br>-HK #1 failed to wash her hands for the appropriate amount of time.<br><br>HK #1 returned to the cart, put gloves on and entered the room to begin cleaning.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | D Staff interviews<br><br>HK #1 was interviewed on 4/22/24 at 2:25 p.m. HK #1 said she was trained by the maintenance director (MTD) when she was hired. She said housekeepers should perform hand hygiene between each glove change and clean all the high touch areas in the residents' rooms, which included remotes and call lights.<br><br>The director of nursing (DON) was interviewed on 4/23/24 at 2:32 p.m. The DON said proper hand hygiene consisted of using hand sanitizer or washing hands with soap and water for at least 20 seconds. She said if hands were visibly dirty staff should use soap and water to sanitize them.<br><br>The DON said hand hygiene should be performed before and after care of residents, before and after gloving, and between different cares for residents.<br><br>The MTD was interviewed on 4/24/24 at 12:45 p.m. The MTD said housekeeping staff were trained by the MTD. He said staff should perform hand hygiene before entering the room, put on gloves, spray all high touch areas and let it sit for 45 seconds. He said housekeeping should start in the bathroom, cleaning all surfaces and the toilet, perform hand hygiene and change gloves before moving to the next part of the room. The MTD said staff should clean the light switch and door handles, exit the room and remove their gloves. He said staff could go into the next resident's room to wash their hands at the sink and then put on gloves. The MTD said staff should wash their hands for 20 seconds with soap and water.<br><br>50315<br><br>II. Staff hand hygiene failures during resident assessment and resident care, use of shared equipment and medication administration<br><br>A. Professional references<br><br>According to the Centers for Disease Control and Prevention (CDC) (January 2021) Hand Hand Hygiene in Healthcare Settings, retrieved on 4/30/24 from https://www.cdc.gov/handhygiene/providers/index.html,<br><br>Cleaning your hands reduces the spread of potentially deadly germs to patients. The risk of healthcare provider colonization or infection caused by germs acquired from the patient. When to perform hand hygiene: immediately before touching a patient, after touching a patient or the patient's immediate environment, after glove removal.<br><br>According to Medline (October 2022) Cleaning medical equipment that's shared: Who's responsible?, retrieved on 4/30/24 from https://www.medline.com/strategies/infection-prevention/cleaning-shared-patient-care-devices-best-practice/#:~:text=Bacteria%20can%20grow%20on%20this,%2Fresidents%2C%20leading%20to%20HAIs.&text=Establishing%20disinfection%20practices%20for%20shared,establishing%20daily%20room%20disinfection%20practices.<br><br>Bacteria can grow on this medical equipment and be transferred among patients/residents, leading to HAIs (health associated infections). Establishing disinfection practices for shared patient/resident devices and equipment is as important as establishing daily room disinfection practices.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | B. Facility policy<br><br>The Hand Hygiene policy, revised August 2019, was received from the corporate director of clinical services (CDCS) on 4/24/24 at 5:13 p.m. It documented in pertinent part, This facility considers hand hygiene the primary means to prevent spread of infections. Use an alcohol-based hand rub or soap and water for the following situations: before and after direct contact with residents, after contact with resident's intact skin, after handling contaminated equipment, after contact with objects in the immediate vicinity of the resident, after removing gloves and before and after entering isolation settings.<br><br>C. Vital signs equipment<br><br>1. Observations<br><br>Certified nurse aide (CNA) #6 was observed on 4/22/24 at 8:50 a.m. CNA #6 was taking vital signs on residents using an automatic vital signs machine. She unplugged the machine from the nurses station and took it into the first resident's room.<br><br>-CNA #6 did not sanitize the vital signs machine prior to obtaining the first resident's vital signs nor did she perform hand hygiene.<br><br>CNA #6 completed the task of taking vital signs on the resident and recorded the vital signs on a clipboard.<br><br>-Without sanitizing the vitals signs equipment or her hands, CNA #6 took the vitals machine into the next resident's room, obtained the resident's vitals signs and recorded the results.<br><br>After obtaining the second resident's vital signs, CNA #6 proceeded to take the vital signs machine to a third resident's room and took the resident's vital signs.<br><br>-CNA #6 did not sanitize her hands or the vital signs machine after obtaining the third resident's vital signs.<br><br>CNA #6 proceeded to a fourth resident's room with the vital signs machine and obtained the resident's vital signs.<br><br>After obtaining the fourth resident's vital signs, took the vital signs machine back to the nurses station and plugged it in.<br><br>-CNA #6 did not sanitize her hands or the machine after plugging the vital signs machine in<br><br>CNA #8 was observed on 4/22/24 at 2:42 p.m. CNA #8 unplugged the vital signs machine from the nurses station and proceeded to a resident's room to obtain the resident's vital signs and record the results on a clipboard<br><br>-Without sanitizing the vitals signs equipment or her hands, CNA #8 took the vital signs machine into the next resident's room and obtained the resident's vital signs and recorded the results.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -After obtaining the second resident's vital signs, and without sanitizing the vital signs machine or her hands, CNA #8 obtained a third resident's vital signs.<br><br>CNA #8 proceeded to a fourth resident's room and obtained the resident's vital signs.<br><br>-CNA #8 did not sanitize the vital signs machine or her hands prior to obtaining the fourth resident's vital signs.<br><br>CNA #8 took the vital signs machine to a fifth resident's room and obtained the resident's vital signs.<br><br>-CNA #8 did not sanitize the vital signs machine or her hands after obtaining the fifth resident's vital signs.<br><br>2. Staff interviews<br><br>CNA #8 was interviewed on 4/22/24 at 3:02 p.m. CNA #8 said hand hygiene should be performed before resident care, between changing gloves and after resident care. She said shared resident equipment should be cleaned between use with different residents.<br><br>The director of nursing (DON) was interviewed on 4/23/2024 at 1:30 p.m. The DON said that all medical equipment should be cleaned and sanitized in between each use.<br><br>D. Mechanical lifts<br><br>1. Observations<br><br>On 4/22/24 at 3:26 p.m. the Spruce Hall unit was observed with three mechanical lifts. Each of the mechanical lifts were heavily soiled and the push-handles were all soiled with a dried brown substance.<br><br>CNA #7 took one of the mechanical lifts, without cleaning the device, to a resident's room and proceeded, with another CNA, to get the resident back into bed using the lift.<br><br>-After getting the resident in bed, CNA #7 placed the mechanical lift back in the hall without sanitizing the device. The push handles were still soiled with the dried brown substance.<br><br>At 3:37 p.m., CNA #7 returned to get the mechanical lift to put another resident back into bed.<br><br>-CNA #7 did not sanitize the mechanical lift before using it with the second resident.<br><br>-The mechanical lift was used an additional two times with different residents. The CNAs failed to sanitize the lift in between use with any of the residents.<br><br>2. Staff interviews<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | CNA #1 was interviewed on 4/23/2024 at 2:00 p.m. CNA #1 said all shared medical equipment, including the mechanical lift, must be sanitized before and after each use. CNA #1 said the CNAs the purple top disinfecting wipes to disinfect the equipment.<br><br>The director of nursing (DON) was interviewed on 4/23/2024 at 1:30 p.m. The DON said the staff should have sanitized the mechanical lift in between each use with a resident.<br><br>E. Medication administration<br><br>1. Observations<br><br>On 4/22/24 at 10:51 a.m., RN #3 was preparing to administer medication to a resident on enhanced barrier precautions (EBP), which required wearing a gown, gloves and a mask. RN #3 walked inside the resident's room with only a mask on for precautions and listened to the resident's heart and lungs and measured his blood pressure. She brought the stethoscope and blood pressure cuff back to her cart and set the equipment down on her cart.<br><br>RN #3 returned to the resident's room, put on a procedure gown and gloves and administered medications through the resident's feeding tube.<br><br>-RN #3 changed her gloves but did not perform hand hygiene between handling the resident's feeding tube and administering eye drops to the resident.<br><br>-RN #3 did not clean the blood pressure cuff or stethoscope after resident use and before storing it in the medication cart.<br><br>2. Staff interview<br><br>The DON, the nursing home administrator (NHA), and the CDCS were interviewed on 4/24/24 at 11:14 a.m. The DON said nursing staff were to perform hand hygiene before and after resident care. She said staff should perform hand hygiene during resident care if gloves were changed. She said the importance of hand hygiene was for infection control purposes. The DON said shared resident equipment should be cleaned between use with different residents for infection control purposes.<br><br>41032<br><br>F. Meal service<br><br>1. Observations<br><br>On 4/21/2024 at 11:13 a.m. the lunch meal was observed. Some residents were already in the dining room finishing up an activity and some residents arrived just before meal service began.<br><br>At 11:28 a.m., staff started to serve beverages to the residents however, no hand hygiene was offered to any resident after the activity ended and before beverages and meals were served to residents. The first meal was served to a resident at 11:41 a.m.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -At 12:02 a.m., staff started to offer residents the opportunity to perform hand hygiene, however, most residents had already started eating and some were finished with their meals by the time staff offered them a squirt of antibacterial hand sanitizer to clean their hands. A couple of residents were offered hand sanitizer just before they started eating.<br><br>At 12:03 p.m. an unidentified woman was standing by a resident at the assisted table talking to one of the residents. The woman had been in the dining room since the start of the meal service.<br><br>Once the meals were served, the woman went to three different tables talking to three different residents. As she talked to the residents she offered each resident assistance to fork up or spoon up food for them then handed them their fork or spoon for them to eat.<br><br>Additionally, the woman handed the residents their napkins and/or drinking cups.<br><br>-In between assisting the residents in this manner, the woman did not perform hand hygiene and frequently stuck her hand into the pocket of her winter coat that she wore throughout the meal service.<br><br>The woman's winter coat was light beige and was visibly soiled with black smudges by the pockets and on the back of the coat.<br><br>There were several CNAs and members of the facility's leadership team present in the dining room during the meal service.<br><br>-None of the facility staff addressed the unidentified woman's behavior or made an attempt to educate her to perform hand hygiene in between assisting the residents with their meals.<br><br>At 12:32 p.m. the business office manager (BOM), the director of medical records (DMR), the maintenance director (MTD) and dietary aide (DA) #1 were interviewed to see if they knew who the woman in the beige coat was.<br><br>-None of the staff had noticed the woman and did not know who she was. The BOM approached the woman, returned and said the woman was a hospice volunteer for one of the residents in the facility.<br><br>-However, none of the residents the woman assisted during the meal was the resident she was assigned to visit.<br><br>On 4/23/2024 at 11:44 a.m. the lunch meal service was again observed.<br><br>-None of the residents in the dining room were offered the opportunity to perform hand hygiene during the meal service.<br><br>2. Staff interviews<br><br>The DON was interviewed on 4/23/24 at 1:30 p.m. The DON said the staff should wash their hands in between serving residents their meals, before assisting residents with their meals and in between moving from resident to resident to provide meal assistance. The DON said the staff should have offered the residents an opportunity to clean their hands before they ate their meals.<br><br>(continued on next page) |

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