STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 20287 Based on observations, record review and interviews, the facility failed to ensure resident rights were promoted and dignity was maintained for seven (#10, #15, #17, #18, #19, #20, and #21) of seven residents out of 21 sample residents. Findings include: I. Facility policy The Resident Rights policy, revised February 2021, was provided by regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident right to a dignified existence, to be treated with respect, kindness and dignity, to self determination and to be supported by the facility in exercising his or her rights. II. Resident group interview The resident group interview was conducted on 7/23/24 at 1:00 p.m. The group consisted of seven residents (#10, #15, #17, #18, #19, #20, and #21) who were interviewable based on assessment and facility. The residents stated they continued to have concerns with being treated with respect and dignity. The concerns were as follows: Residents said they were not allowed to leave the facility without a physician's order. Residents said they could not go to the convenience store which was located across the street from the facility. Residents said they felt like they were treated as if they were children. Residents said they did not understand why they were not allowed to leave the building on their own. One resident said he was in jail at a prior time during his life and being unable to leave the facility made him feel like he was in jail. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Staff interviews The social service director (SSD) and the nursing home administrator (NHA) were interviewed on 7/23/24 at 9:40 a.m. The SSD said residents were not allowed to leave the building without a physician's order pass. She said it was a safety measure because a resident might fall if they walked outside of the building. She said if a resident wanted to leave the building then the nurse would call to get a physician's order for the pass. She said the physician's order pass was usually for four hours. The SSD said two residents were discharged against medical advice because the two residents wanted to leave the building without a physician's order pass. Cross-reference F622 for failure to follow appropriate discharge requirements.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to provide evidence that a quarterly statement was provided to the resident and/or resident representative for two (#9 and #12) of three residents reviewed for personal funds out of 21 sample residents. Specifically, the facility failed to: -Provide Resident #9 and Resident #12 or their legal representatives a copy of the resident's personal funds financial statement on at least a quarterly basis; -Ensure Resident #9 and Resident #12 or their legal representatives reviewed and signed the form required to give the facility authorization to manage the resident's personal funds; and, -Ensure Resident #9 and Resident #12 or their legal representatives were informed when the resident's total funds reached an amount that required a spend down. Findings include: I. Facility Policy The Management of Residents' Personal Funds policy, dated 2021, was provided by regional nurse consultant (RNC) #1. The policy read: Should the resident elect to have the facility manage his or her personal funds, it must be authorized in writing by the resident or the resident's representative and a copy of such authorization must be documented in the resident's record. II. Resident trust fund authorization form The Authorization and Agreement to Manage Resident Funds form read in pertinent part: I authorize the (facility name) to hold safeguard, manage, and account for my personal funds. Resident trust fund account type: -Transferring: By establishing this account, I authorize the (facility name) to transfer my monthly patient responsibility for care costs amount, if any, due to the (facility name) from this resident trust account to the (facility name) operating account. My monthly personal needs allowance remains in my resident trust account. I authorize the (facility name) to adjust my personal needs allowance amount. -Non-Transferring: All funds deposited to this resident trust account remain in this account, until I authorize the withdrawal of funds in writing. My account will be managed as follows: (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. (Facility name) will give me a written receipt for all expenditures and deposits regarding any funds I deposit with (facility name). 2. (Facility name) will maintain a record of all transactions regarding my account in accordance with generally accepted accounting principles. 3. I will have access, at any time upon request, to the above record and will receive an itemized quarterly statement of my account. III. Resident #9 A. Resident status Resident #9 under the age 65, was admitted on [DATE]. The 4/15/24 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 14 out of 15. B. Resident and resident representative interview Resident #9 was interviewed on 7/24/24 at 11:30 a.m. Resident #9 said he was not provided any personal funds statements of his account since admitting to the facility, nor was his legal representative provided the statements. He said they had been trying to get the business office manager (BOM) to provide his personal funds statements to his legal representative but it had not been provided as requested. Resident #9's legal representative and financial power of attorney (FPOA) was interviewed on 7/26/24 at 12:49 p.m. The FPOA said she had been trying to get the facility's BOM to honor her FPOA and send her Resident #9's financial statements, but no one from the facility had responded to her request. The FPOA said she had provided documentation of her FPOA status several times and the facility had still failed to communicate with her about Resident #9 finances, which were managed by the facility. C. Record review Review of Resident #9's Authorization and Agreement to Manage Resident Funds document, dated 4/23/24, revealed the form was not signed by the resident or the resident's legal representative. IV. Resident #12 A. Resident status Resident #12, age 89, was admitted on [DATE]. According to the July 2024 computerized physician's orders (CPO), diagnoses included dementia. The 7/17/24 MDS assessment revealed the resident had severely impaired cognition with a BIMS score of four out of 15. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident representative interview Resident #12's secondary legal representative was interviewed on 7/29/24 at 3:16 p.m. The secondary representative said she was never consulted about Resident #12's finances and was told that she had no say in the resident's finances, despite being the resident's secondary legal representative and being involved in making decisions about the resident's care. The secondary representative said she was aware the resident had a need to spend down money in the past and wanted the resident to get a larger television because the one she had in her room was small and she had a hard time seeing the picture. The secondary representative said she was unsure if that spend down was used or what the facility had spent the money on. Resident #12's primary legal representative was interviewed on 7/29/24 at 3:23 p.m. The primary representative said she was the resident's primary legal representative but she lived out of state so she relied heavily on the resident's secondary legal representative to provide her first hand information about how the resident was doing and be the person to represent Resident #12 in person at the facility. The primary representative said she and the secondary representative collaborated on decision-making to make sure the facility was acting in the best interests of Resident #12. The primary representative said she had never been provided with a copy of Resident #12's financial statements and the facility had been managing the resident's funds since October 2018. C. Record review Review of Resident #12's Authorization and Agreement to Manage Resident Funds documents, dated 10/13/2020 and 4/24/23, revealed the forms were not signed by the resident or the resident's primary or secondary legal representative. V. Staff interviews The BOM was interviewed on 7/29/24 at 2:26 p.m. The BOM said he managed the residents' personal funds accounts and provided the residents, and the residents' representatives when applicable, with quarterly statements of their personal funds accounts. He said when a resident's personal funds account was near or over the allowable total balance, he notified the resident and the social worker that the resident needed to spend down their excess funds to maintain their eligibility for nursing care. The BOM said Resident #9 had a conservator (a person, official, or institution appointed by a court to take over and manage the estate of an incompetent individual) and he believed that he had talked to the conservator about Resident #9's personal funds and the need to spend down his excess funds. -However, Resident #9 was competent and did not have a conservator. On 3/8/23, Resident #9 had self-appointed a legal representative to act as his FPOA on his behalf in all matters of finance, including banking. The BOM said Resident #12 had a guardian and he was working with the resident's guardian to manage the resident's funds and spend down her excess funds. The BOM said the residents' financial statements were last provided for the past quarter at the end of July 2024.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on record review and interviews, the facility failed to ensure each resident was permitted to remain in the facility and not transfer or discharge for three (#6, #4 and #3) of four residents reviewed for discharge out of 21 sample residents. Specifically, the facility failed to: -Have documentation from Resident #6's physician regarding the reason for the resident's facility-initiated discharge; -Document the specific resident need(s) that could not be met at the facility, the facility's attempts to meet the resident's needs and the services available at the receiving facility to meet the resident's need(s) for Resident #6; -Document the discharge planning process in Resident #6's electronic medical record (EMR); -Ensure Resident #6's necessary information, including the resident's comprehensive care plan goals, was provided to the receiving facility; and, -Provide Resident #4 and Resident #3 with an appropriate and safe discharge process. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy and procedure, revised October 2022, was received from regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It revealed in pertinent part, When a resident's discharge is anticipated, a discharge summary and post discharge plan is developed to assist the resident with discharge. Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long term care hospital, or inpatient rehabilitation facility are assisted in selecting a post-acute care provider that is relevant and applicable to resident's goals of care and treatment preference. Data used in helping the resident select an appropriate facility include the receiving facility's standard patient assessment data, quality measure data and data on resource use. A member of the interdisciplinary team (IDT) reviews the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: the evaluation of the resident's discharge needs, the post discharge plan and the discharge summary. II. Resident #6 (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #6, age 66, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included hypertension (high blood pressure), hypothyroidism (decreased function of thyroid), type II diabetes (abnormal glucose control), hemiplegia affecting right side (decreased function on the left side of body) and bipolar (abnormal thought process). The 6/12/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required supervision assistance with dressing and toileting. Resident #6 required set up assistance with eating and personal hygiene. B. Resident interview Resident #6 was interviewed on 7/23/24 at 12:13 p.m. Resident #6 said if residents complained about an issue in the facility, the facility made the residents leave. Resident #6 said he had no intentions of leaving the facility but after he complained about staff, the facility was making him move. He said the facility had him sign a discharge notice on the same day he complained about staff. Resident #6 said the new facility his current facility was transferring him to was further away from his family and would strain their ability to visit him. C. Record review The 6/29/23 comprehensive care plan, revised 3/11/24, revealed Resident #6 was to remain in long term care at the facility as he required 24-hour nursing care. Interventions included reviewing the plan of care/initially/quarterly or as needed and social services was to document changes to the discharge goals per resident preference as indicated. -There was no other documentation on the care plan for discharge/transfer goals or planning. The electronic medical record (EMR) revealed Resident #6 was issued a Nursing Home Notice of Involuntary Transfer or Discharge on 6/14/24. -The involuntary discharge notice failed to document the reason the resident was being discharged or the reason the resident's needs could not be met at the facility. Review of Resident #6's EMR revealed there were no progress notes regarding the resident's discharge to another facility until 7/23/24, the day of the resident's discharge. Further review of Resident #6's EMR revealed there was no physician documentation which detailed the reason for the resident's facility-initiated discharge. D. Staff interviews The medical director (MD) was interviewed on 7/29/24 at 11:15 a.m. The MD said he had not been informed of a facility-initiated 30-day discharge notice for Resident #6. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The against medical advice (AMA) release form, dated 4/23/24, read in pertinent part, This document serves to certify that the above named resident (Resident #4) at the above named facility, is leaving the facility against the advice of the attending physician. The resident acknowledges that he/she has been informed of the risks involved and hereby releases the attending physician and the facility from all responsibility from all ill effects which may result from such discharge. -Resident #4 did not sign the document and there was no documentation to explain why the resident did not sign the document. Review of Resident #4's EMR revealed the following progress notes: A progress note, dated 4/23/24, documented Resident #4 told the nurse she needed to go to the bank and would walk if she had to. She was told by the social service director (SSD) that in-house transportation was not available. Resident #4 said she was going to walk to the bank and informed the nurse that Resident #3 was going with her. The nurse said it was too far and the resident said she was going to go because walking a mile was nothing for her. The nurse notified the DON and the NHA. The social service progress note dated 4/23/24 documented Resident #4 was told that walking to the bank was not advised and a medical pass would be needed from the physician. The resident verbalized understanding but continued to state she was leaving. The progress note further documented Resident #4 was alert and oriented and able to make her own decisions. Resident #4 was aware that if she did walk to the bank it would be against medical advice. -Resident #4's progress notes failed to show that the facility oriented and prepared the resident regarding her discharge in a form and manner that the resident could understand. -Review of Resident #4's EMR failed to show any interventions were tried prior to informing Resident #4 she would be discharged AMA if she left the facility to go to the bank and would not be allowed to return to the facility. -Review of Resident #4's April 2024 CPO did not reveal a physician's order which indicated the resident was unable to leave the facility without a physician's order. -Review of Resident #4's EMR failed to reveal a physician's order or a physician's progress note which documented the reason for the resident's discharge, the resident needs that could not be met by the facility or the attempts made by the facility to meet the resident's needs. IV. Resident #3 A. Resident status Resident #3, age less than 65, was admitted to the facility on [DATE]. According to the April 2024 CPO, diagnoses included fracture of unspecified part of the neck of left femur, type II diabetes, heart disease and need for assistance with personal care. The 3/25/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. He required set up assistance with activities of daily living. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The against medical advice (AMA) release form dated 4/23/24 read in pertinent part, This document serves to certify that the above named resident (Resident #3) at the above named facility, is leaving the facility against the advice of the attending physician. The resident acknowledges that he/she has been informed of the risks involved and hereby releases the attending physician and the facility from all responsibility from all ill effects which may result from such discharge. -Resident #3 did not sign the document and there was no documentation to explain why the resident did not sign the document The form was signed by the nurse and the receptionist. -Resident #3's progress notes failed to show that the facility oriented and prepared the resident regarding her discharge in a form and manner that the resident could understand. -The progress notes did not reveal any documentation in regards to Resident #3 leaving the facility with Resident #4. -Review of Resident #3's April 2024 CPO did not reveal a physician's order which indicated the resident was unable to leave the facility without a physician's order. -Review of Resident #3's EMR failed to reveal a physician's order or a physician's progress note which documented the reason for the resident's discharge, the resident needs that could not be met by the facility or the attempts made by the facility to meet the resident's needs. V. Staff interviews The DON was interviewed on 7/23/24 at approximately 4:00 p.m. The DON said Resident #4 and Resident #3 were discharged against medical advice (AMA) and no medications were sent with the residents. She said the residents were only sent with their personal belongings when they were discharged AMA. The SSD and the NHA were interviewed together on 7/24/24 at 9:40 a.m. The SSD said Resident #4 was discharged against medical advice because she said she wanted to go to the bank. The SSD said the resident was not allowed to leave the facility without a physician's order. She said Resident #4 was not allowed to use the in-house transportation as she had used it before and was rude to the bus driver. The SSD said when Resident #4 went to the bank, she was rude to the bank teller. The SSD said she told Resident #4 if she walked to the bank it was not safe and she could fall. The SSD was unable to provide any interventions which she used in order to help Resident #4 to get to the bank prior to the resident leaving the facility on 4/23/24. She said because the resident insisted she was leaving to go to the bank, she was told it was against medical advice if she left. The SSD said Resident #3 was discharged against medical advice because he was going to accompany Resident #4 to the bank. The SSD said Resident #3 did not have a physician's order to leave the facility alone. She said anytime the resident wanted to leave the facility, a physician's order was needed or it was considered leaving against medical advice. The SSD said Resident #3 was cognitively intact and understood if he left the facility with Resident #4 he would be leaving against medical advice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on record review and interviews, the facility failed to provide notice of discharge to the resident or their representative and the Office of the State Long-term Care Ombudsman at least 30 days before the resident's discharge for one (#6) of four residents reviewed for discharge out of 21 sample residents. Specifically, the facility failed to provide Resident #6 an appropriate written notice of discharge from the facility that included: -The reason for transfer or discharge; -The location to which the resident was being transferred or discharged ; -A statement of the resident's appeal rights, including the name, address (mailing and email) and telephone number of the entity which receives such requests; and, -Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy and procedure, revised October 2022, was received from regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It revealed in pertinent part, When a resident's discharge is anticipated, a discharge summary and post discharge plan is developed to assist the resident with discharge. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of the resident information and as permitted by the resident. II. Resident #6 A. Resident status Resident #6, age 66, was admitted on [DATE] and discharged on [DATE] (during the survey). According to the July 2024 computerized physician orders (CPO), diagnoses included hypertension (high blood pressure), hypothyroidism (decreased function of thyroid), type II diabetes (abnormal glucose control), hemiplegia affecting right side (decreased function on the left side of body) and bipolar (abnormal thought process). (continued on next page)

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Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/12/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He required supervision assistance with dressing and toileting. Resident #6 required set up assistance with eating and personal hygiene. B. Resident interview Resident #6 and a family member were interviewed together on 7/23/24 at 12:13 p.m. Resident #6 said if a resident complained about an issue to the facility staff, the facility would discharge the resident. Resident #6 said he was given a discharge notice on the same day he complained about the staff. Resident #6 said he was being transferred to a facility further away from his family which was going to strain their ability to visit him. Resident #6 said the facility looked for places for him to go but he was not involved with finding a new place. He said he was just told which facility he would be transferred to. Resident #6 said he was unaware of his right to appeal the transfer/discharge but he said, at this point, he did not want to stay in the current facility. C. Record review The resident's electronic medical record (EMR) revealed Resident #6 was issued a Nursing Home Notice of Involuntary Transfer or Discharge on 6/14/24. The notice documented the resident was being transferred or discharged because it was necessary to meet the resident's welfare and the resident's welfare could not be met in the facility. The notice was signed by the nursing home administrator (NHA) and the resident on 6/14/24. The notice revealed only the local long term care ombudsman was notified by the facility on 6/14/24. The form failed to identify: -The location the resident was being transferred to; -That the State Long-term Care Ombudsman was notified of the transfer/discharge; -Information regarding the resident's appeal rights, including the name, address (mailing and email) and telephone number of the entity which receives such requests; and, -Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's EMR failed to provide physician documentation regarding how the facility was unable to provide care to Resident #6, which required him to be transferred/discharged to another facility. A social service progress note on 6/12/24 revealed Resident #6 had a care conference on 6/11/24 and was identified as a long term resident. -There was no documentation to indicate a discussion had taken place at the care conference regarding Resident #6 having behavior concerns or a potential for the resident needing to be transferred or discharged from the facility. -A review of the resident's EMR did not reveal any other progress notes written for transfer/discharge of Resident #6 in the EMR until 7/23/24, the day of transfer/discharge. On 7/23/24 at 12:46 p.m. (during the survey) a social service progress note revealed Resident #6 was aware he was being transferred to another facility and he no longer wanted to be a resident at the facility. III. Staff interviews Registered nurse (RN) #1 was interviewed on 7/29/24 at 2:05 p.m. RN #1 said Resident #6 was transferred to another facility related to behaviors consisting of threats towards others and himself. -However, there was no documentation in the resident's EMR that indicated Resident #6 exhibited behaviors that could not be managed in the facility which required him to be transferred or discharged to another facility. The NHA was interviewed on 7/29/24 at 3:55 p.m. The NHA said transfers/discharges were discussed in the morning stand up meetings. The NHA said he was not aware of the appeal process. He said he reviewed Resident #6's involuntary transfer/discharge paperwork and said he did not see the appeal section on the paperwork Resident #6 signed. The NHA said the facility notified the local ombudsman and he believed the ombudsman could review the appeal process with residents if needed. The NHA said he reviewed additional involuntary transfer/discharge notices and said the facility used two different forms. He said it was up to his business office manager (BOM) on which form was used. The BOM was interviewed on 7/29/24 at 4:22 p.m. The BOM said he only reviewed transfers/discharges during the triple check meeting for billing purposes. He said he did not determine what forms were used in the facility. The NHA was interviewed again on 7/29/24 at 5:15 p.m. The NHA said the facility did not have any records to show why they were unable to provide Resident #6 care to support the involuntary transfer/discharge.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to provide and document sufficient preparation and orientation for one (#2) of three residents out of 21 sample residents to ensure a safe discharge from the facility. Specifically, the facility failed to: -Provide Resident #2 and his representative with the correct information regarding the resident's nutritional and tube feeding needs when the resident was discharged ; -Provide Resident #2 and his representative with discharge education or training related to the resident's feeding tube; and, -Provide Resident #2 and his representative with a discharge summary and discharge instructions in a language they understood. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy and procedure, revised October 2022, was provided by regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It read in pertinent part, Every resident is evaluated for his or her discharge needs and has an individualized post discharge plan. The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge. II. Resident #2 A. Resident status Resident #2, age 73, was admitted on [DATE] and discharged home on 4/23/24. According to the April 2024 computerized physician orders (CPO), diagnoses included malignant neoplasm of the tongue, type 2 diabetes, and sensorineural hearing loss. The 3/25/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required setup assistance with activities of daily living (ADL). The assessment revealed the resident received a therapeutic and mechanically altered diet. B. Resident representative interview (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative was interviewed via phone on 7/22/24 at 11:38 a.m. via a Russian interpreter. The representative said she was the primary caretaker for Resident #2. She said she got the supplies for the resident's tube feeding from his oncologist's office after his discharge because the facility did not provide the supplies when he was discharged . The representative said Resident #2 was currently using the eternal feeding. C. Registered dietitian (RD) interview The registered dietitian (RD) from Resident #2's oncologist's office was interviewed via phone on 7/24/24 at 1:37 p.m. The RD said she saw Resident #2 on 5/17/24, approximately one month after he had been discharged from the facility. She said the resident was not discharged from the facility with any feeding tube equipment and the resident and his representative were not provided any education regarding the resident's feeding tube upon his discharge. The RD said Resident #22 had lost weight and appeared weak since his discharge . She said the resident's representative had told her the resident was only eating handfuls of food, as he was not able to eat much orally due to the resection of his tongue. She said the representative told her the resident had not been using the feeding tube for nutrition after his discharge because the facility had not provided them with tube feeding supplies. D. Record review The discharge care plan, initiated 3/26/24 documented Resident #2 would discharge home with his representative when he had been cleared to discharge home. Pertinent interventions included coordinating medical equipment, pharmacy, home health and in-home support services. Nursing was to provide discharge instructions and education for all physician orders and offer family training with the resident's representative as needed. -Review of Resident #2's electronic medical record (EMR) failed to show documentation which indicated the resident and/or his representative had been provided with training related to the resident's feeding tube and nutritional needs. The 4/19/24 physician's order documented med pass 2.0 was to be administered twice daily after dinner. The resident was no longer NPO (nothing by mouth). The progress note dated 4/22/24 documented a physician's order for the resident to discharge home and a phone number for a translator who could help Resident #2 and his representative with discharge education. The progress note dated 4/23/24 documented Resident #2 discharged home with all of his medications and wound care supplies. Education was provided to the resident and a home health nurse for medication administration and wound care steps. -The progress note failed to document whether the resident would be receiving tube feedings upon discharge or if the resident or the resident's representative was provided with discharge education related to his feeding tube. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's discharge summary dated 4/23/24, which was provided to the resident's representative when the resident was discharged , revealed the dietary and nutritional needs section was left blank. -However, the discharge summary included an attachment which was also provided to the resident's representative when the resident discharged .The instructions on the attachment read in pertinent part, Enteral Feed Order: after meals and at bedtime for hydration/ fluids 150 milliliters (ml) water flush after bolus (a method of administering nutritional formula through a feeding tube using a syringe) feedings. -Additionally, the facility failed to provide the discharge summary and discharge instruction to the resident and his representative in their preferred language of Russian. A 5/17/24 clinical support note from the resident's oncologist office, written by the oncologist's office RD, documented Resident #2 had been eating pureed foods at home, in portions the resident's representative described as handfuls. The resident ate oatmeal and yogurt in the morning on 5/16/24 and had soup and some meat the representative had pureed in a blender for lunch. The resident did not eat dinner on 5/16/24. The representative reported they did not have any tube feeding formula at home because they were not provided any when the resident was discharged from the facility. Resident #2's representative had been flushing water through the resident's feeding tube throughout the day but she said she did not receive any additional education on how to use the resident's feeding tube. E. Staff interview The director of nursing (DON) was interviewed on 7/24/24 at 9:05 a.m. The DON said the Resident #2's tube feedings were discontinued prior to the resident's discharge from the facility. The DON said the resident was eating a full pureed meal a few weeks prior to discharge and therefore he was not discharged with tube feeding formula or tube feeding supplies. She said the resident had been eating pureed food at the facility since 4/19/24. -However, the discharge summary, which was provided to Resident #2's representative when the resident was discharged , failed to document specific dietary and nutritional information and included instructions for providing the resident with water flushes following bolus tube feedings (see record review above).

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to develop and implement an effective discharge planning process for two (#16 and #2) of four residents reviewed for discharge planning out of 21 sample residents. Specifically, the facility failed to: -Ensure the discharge planning process was documented in Resident #16's and Resident #3's electronic medical records (EMR); and, -Ensure the interdisciplinary team (IDT) was a part of the ongoing discharge process for Resident #16 and Resident #3. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy and procedure, revised October 2022, was provided by regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It read in pertinent part, Every resident is evaluated for his or her discharge needs and has an individualized post discharge plan. The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge. II. Resident #16 A. Resident status Resident #16, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included fracture of the left patella (fracture of the knee), major depression and need for assistance for personal care. The 5/15/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with activities of daily living (ADL) but needed set up assistance with lower body extremities. The MDS assessment indicated the resident had an active discharge plan and a referral was made. B. Record review The discharge care plan, initiated on 8/8/23 and revised on 5/31/24, revealed the resident desired to return to an independent living apartment. The goal was for the resident to be discharged when her clinical and rehabilitation goals were met. Pertinent interventions included discussing with the resident and family regarding the discharge planning process and reviewing progress made toward discharge. -The care plan was not updated until 5/31/24, after the resident was discharged . (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/28/24 primary care progress note documented the resident was seen by the primary care provider. The note documented the resident reported feeling frustrated that she was not sure when she would be able to leave the facility. The note documented the resident said the facility was supposed to help her leave, but her discharge was recently put on hold. The resident said she did not know how long it was going to take to discharge. -Review of the resident's progress notes failed to reveal a discharge plan documented for Resident #16 or follow up from the 3/28/24 primary care progress note. The 5/23/24 care conference note documented the resident was going to be discharged on [DATE] to an independent apartment with home health services. -A review of Resident #16's EMR did not reveal documentation indicating the facility had assisted the resident with her discharge goals. -A review of the resident's EMR failed to show the reasons for the discharge and who had made the decision and that the IDT was involved. -A review of the April 2024 CPO did not reveal a physician's order was obtained for the resident's discharge. C. Staff interviews The director of nursing (DON) was interviewed on 7/23/24 at approximately 4:00 p.m. The DON said there was not a physician's order for the resident's discharge. She said the process was to obtain a physician's order prior to the resident's discharge. The social service director (SSD) was interviewed on 7/24/24 at 9:40 a.m. The SSD said Resident #16 was discharged to an independent living facility. The SSD said she reviewed the resident's EMR and said there was no documentation that indicated the discharge plan for Resident #16 or any follow up after the resident's 3/28/24 physician's visit. The social service assistant (SSA) was interviewed on 7/24/24 at 9:45 a.m. The SSA said the resident worked with an independent agency to find housing. The SSA said the facility did not assist with the resident's discharge. III. Resident #2 A. Resident status Resident #2, age 73, was admitted on [DATE] and discharged on [DATE]. According to the April 2024 CPO, diagnoses included malignant neoplasm of the tongue (cancer of the tongue), type II diabetes and sensorineural hearing loss. The 3/25/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. He required set up assistance with ADL. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment documented the resident had an active discharge plan, however a referral was not made, as it was not wanted. B. Record review The discharge care plan, initiated on 3/26/24, revealed the resident's goal was to be discharged home to live with his wife when cleared to be discharged . The goal was to have a safe transition to home. Pertinent interventions included coordinating durable medical equipment, coordinating home health and the nursing staff to provide discharge instructions and education for all physician's orders. -The care plan was not updated throughout his stay. -A review of the resident's progress notes failed to reveal a documented discharge plan for Resident #2. -The resident's EMR failed to document the reasons for the discharge, who had made the decision to discharge and that the IDT was involved. The 4/23/24 progress note documented the resident was discharged home with all medications and wound care supplies. Home health care was arranged. Education was provided for medication administration and wound care steps. -The progress notes and care plan failed to reveal that the facility had a discharge plan which was a safe discharge. C. Staff interviews The SSD was interviewed on 7/24/24 at 9:40 a.m. The SSD said Resident #2 was discharged to his home with his wife. She said she reviewed the resident's EMR and said there was no information or plans documented for the resident's discharge. She said when a resident desired to return to home, a plan should be created and services, such as home health care, arranged. RNC #1 was interviewed on 7/24/24 at 10:00 a.m. RNC #1 said the social work consultant would ensure the SSD received education on the discharge planning process.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to ensure a discharge summary was in place for three (#2, #3 and #4) of four residents reviewed for discharge out of 21sample residents. Specifically, the facility failed to ensure discharge summaries included a recapitulation of the resident's stay and/or a final summary of the resident's status was completed for Resident #2, #3 and #4. Findings include: I. Facility policy and procedure The Discharge Summary and Plan policy and procedure, revised October 2022, was provided by regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It read in pertinent part, The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the residents status at the time of the discharge in accordance with established regulations governing release of resident information as permitted by the resident. The discharge summary shall include a description of the resident's:current diagnoses; medial history;course of illness, treatment, and or therapy since entering the facility;current laboratory, radiology, consultation and diagnostic tests;physical and mental function;ability to perform activities of daily living;sensory and physical impairments;nutritional status and requirements including weight, nutritional intake and eating habits, preferences and dietary restrictions; special treatments; mental and psychosocial status; discharge potential; dental condition; activities potential; rehabilitation potential; cognitive status; and, mediation therapy. II. Resident #2 A. Resident status Resident #2, age 73, was admitted on [DATE] and discharged on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included malignant neoplasm of tongue (cancer of the tongue), type II diabetes, and sensorineural hearing loss. The 3/25/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15 . He required setup assistance with activities of daily living (ADL). B. Record review The discharge summary, dated 4/16/24, documented the resident was discharged to his home with his wife. The discharge summary failed to show that all areas on the form were completed. -A review of the 4/16/24 discharge summary in the resident's electronic medical record (EMR) revealed the following areas were missing: (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Physical and mental functional status including ADLs; -Mental, psychosocial and behavior status; -Cognitive status; -Dietary and nutritional status; -Activities potential; -Sensory and physical impairments; -Medial history; -Course of illness, treatment and/or therapy since entering the facility; and, -Current laboratory, radiology, consultation and diagnostic tests. III. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the April 2024 CPO, diagnoses included fracture of unspecified part of the neck of left femur, type II diabetes, heart disease and need for assistance with personal care. The 3/25/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. He required setup assistance with all ADLs. B. Record review -A review of Resident #3's EMR failed to show that a nursing summary with the recapitulation of the resident's stay was completed upon discharge. IV. Resident #4 A. Resident status Resident #4, age 66, was admitted on [DATE] and discharged on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included calculus of bile duct with cholecystitis (gallstones), post traumatic stress disorder (PTSD), borderline personality disorder and need for assistance with personal care. The 3/25/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. He required setup assistance with all ADLs. B. Record review (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #4's EMR failed to show that a nursing summary with the recapitulation of the resident's stay was completed upon discharge. V. Staff interviews Regional nurse consultant (RNC) #1 was interviewed on 7/23/24 at approximately 4:00 p.m. RNC #1 said, after reviewing Resident #3 and Resident #4's EMR, there was not a discharge summary. She said Resident #2's discharge summary was incomplete. The social service director (SSD) interviewed on 7/24/24 at 9:40 a.m. The SSD said she opened the discharge summary for a resident who was discharging and informed the interdisciplinary team (IDT) to complete their designated portions. She said the summary was to be completed on the resident's day of discharge. She said the discharge summary, the medication list and any pertinent information was provided to the family or the receiving facility. RNC #2 was interviewed on 7/29/24 at 3:30 p.m. RNC #2 said the nurse manager or discharging nurse was to ensure the discharge summary was complete prior to the residents' discharge. The director of nursing (DON) was interviewed on 7/29/24 at 3:36 p.m. The DON said she was not aware the nurse manager or the discharging nurse was responsible to ensure the discharge summary was complete prior to the residents' discharge.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review, and interviews, the facility failed to provide one of three residents (#5) out of 21 sample residents, with timely and necessary treatment and services to prevent and manage an avoidable, facility-acquired pressure injury that resulted in the development of a stage 4 coccyx wound with osteomyelitis. Resident #5, who had a diagnosis of paraplegia, was admitted on [DATE] with intact skin. The resident was discovered with an unstageable pressure injury on his coccyx on 11/28/23, 14 days after admission. By 1/2/24, the pressure injury had progressed to a stage 4 pressure injury (full-thickness tissue loss with exposed bone, tendon, or muscle). And, on 6/6/24, x-rays revealed the presence of osteomyelitis, inflammation of the bone due to infection, requiring an extended course of antibiotic treatment. Interviews, observations, and record review revealed the facility failed to provide timely and necessary treatment and services to prevent the development of the resident's pressure injury and then, failed to provide the treatment and services necessary to manage the pressure injury and promote healing. Specifically: -Record review and interviews revealed the facility failed to timely provide Resident #5 with devices for pressure relief. Record review revealed a physician's order for an air mattress was not initiated until 2/21/24, approximately two and a half months after the pressure injury had developed and the order was not implemented until 3/10/24, 20 days later. Even then, the air mattress provided had been previously used and the facility was unable to provide documentation on how old the mattress was and how much use it had received, as well as provide an instruction manual on its proper use and settings. Further, an interview with Resident #5 revealed he was not repositioned routinely at night time unless he asked staff to do so. His care plan failed to include a directive for staff to assist the resident in turning and repositioning to offload pressure until 2/21/24, over a month after his pressure injury was assessed as a stage 4. -Record review revealed weekly skin assessments were not completed to ensure Resident #5's pressure injury was regularly monitored; physician orders for dressing changes were not followed and dressing changes were not performed in a manner to prevent infection. -Interviews, record review, and observations revealed the facility failed to ensure the nutritional support ordered on 2/21/24 (double protein) was consistently offered to Resident #5. Per the WCP, interviewed on 7/24/24 at 9:56 a.m., Resident #5's pressure injury was avoidable; he saw no other clinical issues that would contribute to the pressure injury. The facility's systemic failure to provide Resident #5 with timely and necessary treatment and services to prevent and manage his worsening pressure injury created an immediate jeopardy situation with the likelihood of serious harm to other residents with similar conditions. (continued on next page)

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	065241	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Post Acute	290 S Monaco Pkwy Denver, CO 80224

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Findings include: I. Immediate Jeopardy A. Findings of immediate jeopardy Resident #5, who had a diagnosis of paraplegia, was admitted on [DATE] with intact skin. The resident was discovered with an unstageable pressure injury on his coccyx on 11/28/23, 14 days after admission. By 1/2/24, the pressure injury had progressed to a stage 4 pressure injury (full-thickness tissue loss with exposed bone, tendon, or muscle). And, on 6/6/24, x-rays revealed the presence of osteomyelitis, inflammation of the bone due to infection, requiring an extended course of antibiotic treatment. Interviews, observations, and record review revealed the facility failed to provide timely and necessary treatment and services to prevent the development of the resident's pressure injury and then, failed to provide the treatment and services necessary to manage the pressure injury and promote healing. Specifically: -Record review and interviews revealed the facility failed to timely provide Resident #5 with devices for pressure relief. Record review revealed a physician's order for an air mattress was not initiated until 2/21/24, approximately two and half months after the pressure injury had developed and this order was not implemented until 3/10/24, 20 days later. Even then, the air mattress provided had been previously used and the facility was unable to provide documentation on how old the mattress was and how much use it had received, as well as provide an instruction manual on its proper use and settings. Further, an interview with Resident #5 revealed he was not repositioned routinely at night time unless he asked staff to do so. His care plan failed to include a directive for staff to assist the resident in turning and repositioning to offload pressure until 2//21/24, over a month after his pressure injury was assessed as a stage 4. -Record review revealed weekly skin assessments were not completed to ensure Resident #5's pressure injury was regularly monitored; physician orders for dressing changes were not followed and dressing changes were not performed in a manner to prevent infection. -Interviews, record reviews, and observations revealed the facility failed to ensure the nutritional support ordered on 2/21/24 (double protein) was consistently offered to Resident #5. Per the WCP, interviewed on 7/24/24 at 9:56 a.m., Resident #5's pressure injury was avoidable; he saw no other clinical issues that would contribute to the pressure injury. The facility's systemic failure to provide Resident #5 with timely and necessary treatment and services to prevent and manage Resident #5's pressure injury, resulting in a stage 4 wound with osteomyelitis, created an immediate jeopardy situation with the likelihood of serious harm to other residents with similar conditions. B. Notice of immediate jeopardy (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/24/24 at 6:39 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: Completion date of 7/25/24 Medical records review was completed on all residents by the director of nursing/designee to ensure weekly skin assessments were completed and treatments recommendations/orders were in place. A care plan audit was conducted by the director of nursing (DON)/designee to ensure that treatment recommendations/orders were on the care plan that the care plan was being followed. The DON/Designee audited all wound care orders to ensure that treatment orders from providers matched orders in the treatment administration record (TAR). All facility policies and procedures related to skin care, wound care and pressure injury prevention were reviewed and revised as needed. An audit of all pressure relieving devices and support surfaces was conducted by the DON/Designee. The DON/designee provided education to all nursing staff regarding the settings of resident air mattresses and how to ensure proper functioning. The DON/designee provided education to all licensed nurses on facility policies and procedures related to skin/wound care, as well as appropriate wound treatment measures. This included ensuring related residents had necessary support surface and pressure relieving devices. The DON/designee provided education to all licensed nurses on appropriate documentation which included transcription and entering of treatment orders on the physician's order sheet in the electronic medical record (EMR) and the residents TAR. The DON/Designee educated all nurse aids on preventative skin care. The consultant registered dietician provided education to the facility dietician which included professional standards and follow up on supplement recommendations. All residents returning from the hospital treatment recommendations/orders and wound care appointments will be transcribed and overseen by the DON/Designee. A QAPI PIP (quality assurance and performance improvement plan) has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented monthly at the QAA meeting. monitoring/auditing and reporting will continue for a minimum of three months. D. Removal of immediate jeopardy (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility plan was accepted by the state survey agency on 7/25/24 at 4:00 p.m., based on the systemic changes outlined in the above plan to ensure pressure injuries would be immediately addressed through assessment, monitoring, and treatment. The immediate jeopardy situation was removed; however, the deficient practice remained at level G, isolated, actual harm. II. Professional references 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 7/30/24, Pressure ulcer classification is as follows: 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 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 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. Support surfaces 1. According to Joerns Healthcare PRO [NAME] Plus product details, retrieved online from https://www.joerns.com/product/p-r-o-matt-plus/ on 8/5/24, The P.R.O. [NAME] Plus is a non-powered mattress replacement system featuring our Pressure Redistribution Optimization (P.R.O.) Technology. With the addition of an optional control unit, the mattress provides powered immersion or alternating pressure therapy, allowing facilities to use one mattress for both pressure injury prevention and treatment. The P.R.O. Matt(R) Plus system is designed for a minimum service life of five (5) years, subject to the use and maintenance procedures stated in this manual. The P.R.O. [NAME] Plus is a reactive surface that allows the provision of optimal interface pressures through controlled air cell inflation for at-risk patients in the prevention and treatment of Stage 1 and 2 pressure injuries, and treatment of uncomplicated Stage 3 and 4 pressure injuries in patients with multiple turning surfaces. For Stage 3 and/or Stage 4 treatment, care staff should be able to position the patient off of the pressure wound in at least 2 positions. 2. According to Avacare Medical the How Long Can a Air Mattress Last, retrieved on 7/29/24 from: https://www.avacaremedical.com/blog/how-long-can-a-air-mattress-last.html#:~:text=Air%20mattresses%20can%20endure%20for,sharp%20items%20to%20prevent%20punctures, Air mattresses can assist with medical issues like pressure reduction or better blood circulation. Air mattresses can endure for two to eight years when properly maintained and used occasionally. When the air mattress isn ' t in use, thoroughly deflate it and put it in a carry bag to extend its lifespan. Keep the air mattress in a cool, dry area free of sharp items to prevent punctures. Don ' t over inflate the air mattress; avoid sitting on the edge of an inflated air bed to avoid seams ripping and bulging. III. Facility policy A. The Prevention of Pressure Injuries policy and procedure, revised April 2020, was received from regional nurse consultant (RNC) #1 on 7/24/24 at 10:17 a.m. It read in pertinent part: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[P]purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Assess the resident on admission (within eight hours) for existing pressure injury risk factors, repeat the risk assessment weekly and upon any changes in condition. Reposition all residents with or without risk of pressure injuries or an individualized schedule, as determined by the interdisciplinary care team. Choose a frequency for repositioning based on the resident ' s risk factors and current clinical practice guidelines. Provide support devices and assistance as needed Select appropriate support surfaces based on the residents' risk factors in accordance with current clinical practice. B. The Supportive Surfaces Guidelines Policy was provided by RNC #1 on 7/25/24 at 11:30 a.m. The policy read in pertinent part: [T]he purpose of this procedure is to provide guidelines for the assessment of appropriate pressure-reducing and relieving devices for residents at risk of skin breakdown. Redistributing supportive surfaces are to promote comfort for all bed or chair-bound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. Supportive surfaces alone are not effective in preventing pressure ulcers, but studies indicate that the use of appropriate support surfaces with interventions such as turning, repositioning and moisture management can assist in reducing pressure ulcer development. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as a foam, gel, static air alternating air, or air loss mattress when lying in bed. For resident(s) who recline and are dependent on staff for repositioning, change their position at least every two hours IV. Resident #5 A. Resident status on admission Resident #5, age younger than 65, cognitively intact, with a diagnosis of paraplegia per his 6/11/14 minimum data set (MDS) assessment, was admitted to the facility on [DATE]. A skin assessment completed on admission (11/7/23) revealed Resident #5's skin was intact. In an interview on 7/24/24 at 11:30 a.m., registered nurse (RN) #1 and RNC #1 confirmed the resident's admission assessment documented the resident entered the facility with his skin intact. B. Resident status following admission - development, and worsening of a pressure injury on the resident's coccyx. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/10/23, a comprehensive skin assessment revealed Resident #5 had redness to his coccyx, and on 11/28/23, 14 days after admission, a wound physician's note revealed an unstageable pressure injury of the resident's coccyx. The onset of the coccyx wound on 11/28/24 was confirmed by RN #1 in an interview on 7/24/24 at 11:30 p.m. On 1/2/24, a wound physician's progress note identified the pressure injury as a stage 4 wound (full-thickness tissue loss with exposed bone, tendon, or muscle). On 6/4/24, an x-ray of the coccyx was ordered to rule out osteomyelitis, which was confirmed on 6/6/24. According to 6/12/24 skin/wound progress notes, on 6/11/24, the wound physician recommended a six-week course of antibiotics to treat the infection. On 7/24/24 at 9:56 a.m. the WCP was interviewed. He said Resident #5 had an avoidable facility-acquired pressure injury to his coccyx. The WCP said Resident #5 had no other clinical issues that could contribute to the wounds. The WCP was unaware of any changes in Resident #5 daily routines that could have contributed to the development or worsening of the pressure injury. The WCP said he noticed the wound was not healing so he suspected osteomyelitis and had an x-ray taken to confirm this diagnosis. The WCP said osteomyelitis requires a long-term use of antibiotics and residents need antibiotics moving forward for a minimum of six weeks. The WCP said Resident #5's wound had become stagnant so he cultured the wound. The WCP said the wound culture provided insight into the infection in the wound and what antibiotics would be successful in the treatment of the resident's osteomyelitis. The WCP said Resident #5 antibiotics had to be changed to medication that could kill the organisms. The WCP said any opening on the skin exposes the body to the environment which can lead to the colonization of bacteria leading to infection. The WCP said providing good wound care to an open area was important to prevent infections and many types of dressings can be used for healing so it was important to be done correctly. On 7/16/24, a coccyx wound culture was collected by the WCP. On 7/18/24, an order was written for placement of a peripherally inserted central catheter (PICC- used to administer intravenous medication) and, on 7/19/24, Cefepime (antibiotic) 2 grams and Vancomycin (antibiotic) 1500 mg IV (intravenous) was ordered for osteomyelitis. C. Facility failures 1. Record review and interviews revealed the facility failed to implement pressure-reducing measures to provide pressure relief and promote healing. a. Delay in initiating an air mattress and failure to ensure the air mattress was properly functioning to be effective. Record review: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review revealed an order for an air mattress was not initiated until 2/21/24, seven and a half weeks after the coccyx wound was identified as unstageable. The resident's 11/7/24 comprehensive care plan further revealed an air mattress was not placed until 3/10/24, 20 days after the 2/21/24 order. Interviews and observations: Resident #5, interviewed on 7/24/24 at 4:36 p.m., said his current mattress was broken. Resident #5 said that the one he had before was worse. Resident #5 said that the laundry director told him this was the best mattress she could find. The resident was observed lying in his bed on an air mattress with a fitted sheet over the mattress. CNA #1 was interviewed on 7/24/24 at 4:31 p.m. CNA #1 said she checked the resident's air mattress when she did her morning rounds. She said she pushes on the mattress to ensure it is inflated and feels firm to touch. Regional nurse consultant (RNC) #1 and the DON were interviewed on 7/24/24 at 4:00 p.m. The RNC #1 said the facility did not have a system to track equipment repairs needed. The RNC said the only documentation to show when the air mattress currently on the resident's bed was ordered was 2/21/24. RNC #1 was interviewed again on 7/25/24 at 10:33 a.m. RNC #1 said the facility was unable to obtain the operator ' s manufacturer manual for the low-loss air mattress currently placed on Resident #5 ' s bed because the mattress was so old that it was no longer being manufactured or sold by any vendors. RNC #1 was unable to verify the age of the mattress or previous usage of the mattress. She said for that reason, the mattress will be replaced today in the afternoon when the resident gets out of bed. Licensed practical nurse (LPN) #3 was interviewed beginning on 7/29/24 at 9:42 a.m. She said air mattresses were not to have fitted sheets on them as it could restrict the function of the air mattress airflow. The resident's replacement air mattress, a P.R.O [NAME] Plus, was reviewed with LPN #3 for proper function and settings. The air mattress was set at #3 mode therapy and no cycle time. LPN #3 said the air mattress was not set to the right settings based on the physician's order and she needed to get the order clarified to match the settings available on the air mattress pump. The laundry director (LD) was interviewed on 7/29/24 at 10:33 a.m. The LD said she was responsible for managing and placing air mattresses on residents' beds once ordered. -The LD said she was responsible for making sure the mattresses were functioning properly. The LD said she did not monitor the function or integrity of the actual mattress; rather, she only referenced monitoring the pump and its function. When a mattress was not able to hold air and was not making the normal whooshing sounds she said she replaced the mattress pump but did not change out the actual mattress. The LD said the facility had several backup pumps in stock. Malfunction pumps were discarded. -The LD said the facility had recently purchased a couple of new pressure-relieving air mattresses but most of the air mattresses in stock were older and had been acquired by the previous facility owners. Some of the air mattresses were used more than others and they no longer tracked the age or length of time a mattress was used by one of the residents in the facility. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-The LD said the facility did not have the manufacturer's manuals for the air mattresses and they did not know the exact age of the mattresses in stock. The LD said she did not know how old the mattress that Resident #5 had been using was or how much time it had been in use by other residents before it was placed on his bed. -The LD said the resident had been complaining about the mattress that was on his bed, saying that it was uncomfortable and was causing him a great deal of discomfort. The LD said she changed out his mattress on 7/28/24 (during the survey) with a new mattress that was approximately a month or two old. -The LD said the lifespan of a pressure-relieving air mattress was dependent upon how long it was in use. She was not sure but thought that an air mattress under continuous use was only effective for pressure relief for a year or two. The NHA confirmed the facility did not have a tracking system to determine how long the older pressure-relieving air mattress had been in use. The NHA said Resident #5 ' s mattress was changed to a newer mattress (on 7/28/24) when the facility was unable to verify the age or usage of the mattress on the resident's bed. b. Failure to timely and consistently implement turning and positioning of the resident. A review of the resident's 11/7/23 comprehensive care plan revealed a directive for staff to assist the resident in turning and repositioning as indicated/tolerated was not initiated until 1/3/24, about a month after the resident's wound was identified and after the wound physician's progress note identified the pressure injury as a stage 4 pressure injury, CNA #1, interviewed on 7/24/24 at 4:31 p.m., said Resident #5 was dependent on staff for positioning due to his medical condition. She said the resident did not refuse care when offered. Resident #5 was interviewed on 7/24/24 at 4:36 p.m. and said that the last time he got up in his wheelchair was last week for 2 to 6 hours. He said he gets up when he wants to. He said the CNAs come in to reposition him when he asks or if he needs to go to the bathroom. Resident #5 said at night, they do not come in and reposition him unless he asks them to. 2. Record review, observations, and interview revealed weekly skin assessments were not completed to ensure Resident #5's pressure injury was regularly monitored; physician orders for dressing changes were not followed and dressing changes were not performed in a manner to prevent infection. a. Weekly assessments March: -On 3/7/24 - no skin assessment was completed -On 3/14/24 - no skin assessment was completed April: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-On 4/3/24 - no skin assessment was completed -On 4/17/24 - no skin assessment was completed May: -On 5/2/24 - no skin assessment was completed -On 5/23/24 - no skin assessment was completed June: -On 6/27/24 - no skin assessment was completed b. Orders and dressing changes Orders: A 12/4/23 wound care order read: clean wound to the coccyx with normal saline and apply clean dressing until it was assessed by the wound care team. -However, Resident #5 was seen by the wound physician on 11/28/23, per the 11/28/23 wound physician's note. As such, the order for dressings change was added 7 days after Resident #5 was seen by the wound physician. A 6/21/24 wound care order read: coccyx - cleanse with quarter strength Dakin's (used for cleaning) solution, apply skin barrier cream with zinc to peri wound, cut and apply silver alginate to wound bed, Cover with border gauze dressing. Change dressing every other day. -However, the June 2024 treatment administration records (TARs) revealed Resident #5 received dressing changes daily from 6/23 to 6/25/24. (This treatment order was discontinued on 6/25/24.) A 6/26/24 wound care order read: coccyx - cleanse with quarter strength Dakin's solution, apply barrier cream with zinc to peri-wound (around wound edges but not in the wound), cut and apply hydrofera blue (specialized wound dressing) to wound bed, cover with border gauze change dressing every other day. Order was discontinued on 7/2/24. -However, the June 2024 TAR record revealed Resident #5 dressing was changed daily from 6/26 to 6/30/24, and 7/1 to 7/2/24. The DON was interviewed on 7/24/24 at 12:34 p.m. The DON said the physician should be called when wound care was not administered per the physician's orders. Infection control: On 7/25/24 at 11:50 a.m., Resident #5 was observed receiving care for his coccyx wound. The DON, RN #1, and CNA #1 were present for wound care. Wound care was completed as ordered during observation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-However, RN #1 failed to place a barrier pad under the resident's wound during care. RN #1 was interviewed on 7/25/24 at 12:25 p.m. RN #1 said she should have placed a barrier pad under the resident during wound care to protect him and the linen from being contaminated during wound care. RN #1 said not placing a barrier pad could put the resident at risk for germs to get into the wound. 3. Interviews, record reviews, and observations revealed the facility failed to ensure the nutritional support ordered on 2/21/24 (double protein) was consistently offered to Resident #5. Record review revealed on 2/13/24, an order for a double protein diet was initiated. Dietary aide (DA) #1 was interviewed on 7/25/24 at 3:51 p.m. He said meal tickets for residents will identify special diet considerations in bold letters and allergies were highlighted. DA #1 said a double protein diet means they get two servings of protein items served. DA #1 said protein items were eggs, meat, milk, and cheese. -However, observations revealed the resident was not served double protein: On 7/23/24 at 1:20 p.m., the resident was served two ham and cheese sandwiches. The tray card had written in double ham. However, the ham sandwiches did not have double ham. The sandwiches had one slice of ham and a slice of cheese. At approximately 2:00 p.m., the resident consumed one of the ham and cheese sandwiches. On 7/24/24 at 12:25 p.m., the resident received his meal. The resident received two ham and cheese sandwiches. The dietary tray ticket instructed double protein, and in writing the ticket wrote double ham. The sandwiches had a slice of ham and a slice of cheese. The sandwiches did not have double meat. On 7/24/24 at 12:45 p.m., the registered dietitian consultant (RDC) observed the sandwich served to the resident. She confirmed it was not double the ham. The RDC asked the resident if he would like additional meat for his sandwich and he replied It is a little late, as he had consumed the majority of the sandwich. The registered dietitian (RD) was interviewed on 7/24/24 at 4:55 p.m. -The RD said Resident #5 told her he wanted to have double protein in his meals, as he did not want the health shake of beneprotein. The RD said that the resident was refusing the dinner health shake she discontinued the order for health shakes (4/19/24) although the RD confirmed the resident was consuming the morning and afternoon administrations. The RD said only the dinner beneprotein could have been discontinued, however, the resident had said he did not want to have it any longer and was now receiving double protein. But see observations above; the resident was observed not receiving double protein. -The RD said Resident #5 was not reviewed in a nutrition-at-risk meeting. The RD said she was aware the pressure wounds were worsening. The RD said the zinc and the vitamin C were recently bumped up a week due to the worsening. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	IV. Final interviews with the administration The NHA was interviewed on 7/29/24 at 11:05 a.m. The NHA said the interdisciplinary team (IDT) conducted daily clinical discussions which included talking about residents' wound and wound care needs. The NHA said he did not recall discussing Resident #5 ' s wound status and was not aware that Resident #5 ' s coccyx wound was infected. The NHA said he was more involved in working with the IDT on revamping the overall care and treatment programs for all residents, rather than knowing the individual treatment needs of each resident. The NHA said the DON took on the role of meeting the individual clinical needs of the residents. The NHA said he was working with the new DON to hire a full-time treatment nurse who would be tasked with managing resident wound care needs and working directly with the WCP to ensure proper treatment of the residents' wounds. The NHA said his goal was for the nursing department to make improvements in tracking and auditing the residents' wound care and treatment needs. The DON was interviewed on 7/29/24 at 11:15 a.m. The DON said she no longer followed the WCP. Instead, the wound care nurse was tasked with tracking the p[TRUNCATED]

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41032 Based on interviews and record review, the facility failed to ensure that all nursing staff had the specific competencies and skill sets necessary to identify, intervene, and notify the physician of residents' acute changes of condition related to wound development and treatment measures such as providing wound care and management of pressure relieving mattresses. This affected all residents with pressure wounds or those at risk for developing a pressure wound and contributed to Resident #5's pressure wound from worsening to a Stage 4 pressure wound with osteomyelitis (infection at the bone). Cross-reference F686 for failure to prevent worsening of a pressure injury. Specifically, the facility failed to assess all facility-hired nurse staff registered nurses (RNs), licensed practical nurses (LPNs) and certified nurse aides (CNAs) for competency in caring for residents with pressure injuries. Competencies not assessed included all of the following: reporting and documenting when a resident developed a new or worsening wound, assessing the condition or a wound, development and implementation of care plan interventions, ensuring and promoting healthy skin and healing of impaired skin; administration of physician-ordered treatments, and application and implementation of pressure relieving mattresses. Findings Include: I. Facility Policy The Staffing, Sufficient and Competent Nursing policy, revised August 2022, was provided by the nursing home administrator (NHA) on 7/29/24 at 4:38 p.m. It read in pertinent part: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competencies necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of the respective relationship and certification requirements defined by state law. Staff must demonstrate the skills and techniques necessary to care for the resident's needs, including but not limited to, the following areas: basic nursing skills, skin and wound care and identification of changes in condition. Licensed nursing and nursing assistants are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities. Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Programs for staff trained results in nursing competency; -Gaps in education are identified and addressed; -Education topics and skills needed are demonstrated based on the resident population; -Tracking or other mechanisms are in place to evaluate the effectiveness of training; and, -Training includes critical thinking skills and management care and complex environments with multiple interruptions. II. Record review On 7/25/24, a request was made to the regional nurse consultant (RNC) #1 and the NHA for the facility's annual competency assessment for all nursing staff. -The facility was unable to produce any documentation to show that the facility's licensed nurses had the specific skill sets necessary to provide competent care for residents' needs, as identified through resident assessments and described in the plan of care for residents with pressure injuries. -Additionally, the facility was unable to produce any documentation to show that the facility's CNAs had the specific skills to provide competent care for residents' needs, as identified through resident assessments and described in the plan of care for residents with pressure injuries. III. Interviews The NHA was interviewed on 7/29/24 at 2:22 p.m. The NHA said the new leadership took over ownership of the facility in April 2024 and they had not yet started the process to assess the competency of the nursing staff.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review and interviews, the facility failed to assist residents in making transportation arrangements to and from the source of service for one (#9) of one resident reviewed for medical transportation out of 21 sample residents. Specifically, the facility failed to assist Resident #9 with scheduling medical transportation by a gurney for a follow-up appointment with a urologist (a physician specializing in conditions that affect the urinary tract). Findings include: I. Facility policy and procedure The Transportation policy, revised December 2008, was provided by the nursing home administrator (NHA) on 7/25/24. It read in pertinent part, Our facility will assist residents in arranging transportation to/from diagnostic appointments when necessary. Should it become necessary to transport a resident to a diagnostic service outside the facility, the social service designee or charge nurse shall notify the resident's representative (sponsor) and inform them of the appointment. The resident's representative (sponsor) will be responsible for transporting the resident to his or her lab appointment. Should it become necessary for the facility to provide transportation, the social service designee will be responsible for arranging the transportation through the business office. A member of the nursing staff, or social services, will accompany the resident to the diagnostic center when the resident's family is not available. Requests for transportation should be made as far in advance as possible. The use of volunteers to transport residents to appointments must be approved by the administrator. II. Resident #9 A. Resident status Resident #9, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included paraplegia (paralysis of the lower body), acute transverse myelitis of the central nervous system (swelling of the spinal cord that interrupts the messages that the spinal cord nerves send throughout the body, which can cause pain, muscle weakness, paralysis, sensory problems), osteoporosis, neuromuscular dysfunction of the bladder (a condition that affects the muscles in the bladder), benign prostatic hyperplasia (BPH) and reduced mobility. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/15/24 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 had impaired lower extremities (hips, knees, ankles and feet). B. Resident and resident representative interview Resident #9 was interviewed on 7/23/24 at 2:00 p.m. Resident #9 said he was not able to get out of bed and into a wheelchair without being in pain due to the contractures in his legs. Resident #9 said he said he was unable to bend his legs and needed to be transported to his physician's appointments in an ambulance on a hospital gurney. He said the facility was not assisting him in securing transportation via a hospital gurney. He said, as a result, he missed two urology appointments because he was told that his insurance provider would not pay for the transportation in an ambulance with a gurney. Resident #9 said he was told that it would cost him $700.00 out of pocket if he wanted to go to his appointments with his gastrointestinal (GI) specialist and the urologist his physician had referred him to. He said the facility told him that they would not pay for the transportation on his behalf. He said it was frustrating because the facility did not listen to his needs. Resident #9's legal representative was interviewed on 7/26/24 at 12:49 p.m. The legal representative said the resident had contractures in both legs and it was extremely painful for him to sit in a manual wheelchair for long periods. The legal representative said the resident would be unable to tolerate the drive to the physician's office, the wait in the office and the transport back to the facility without being in extreme pain due to the restrictive positioning. Resident #9's legal representative said the resident had missed his urology appointment and three appointments to see his GI physician. The representative said it was important for the resident to see the GI physician because he had chronic constipation and was hospitalized in the past for a bowel obstruction which required surgical intervention. Resident #9's legal representative said she had informed the nursing staff numerous times that he had scheduled appointments with the GI physician but no one took the time to seek out insurance approval for the needed gurney transportation, despite the resident's primary care physician's request for the facility to seek approval for this type of transportation. Resident #9's legal representative said the facility had given them many excuses for not securing approval for the resident's gurney transportation. She said the facility first told her the resident's insurance provider would not cover the gurney transportation and said gurney transportation was too expensive. She said the last time she talked to the facility, the staff said they had to fill out a lot of paperwork to request approval for the gurney transportation. She said the facility had still not taken action to secure insurance approval for the gurney transportation so the resident would be able to go to his preferred physician and urologist that his primary care physician had referred him to. C. Record review (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's comprehensive care plan, revised on 6/19/24, revealed the resident had contractures in both lower legs and was at risk for decline and/or complications with range of motion in the joints, decreased mobility and movement, decreased muscle strength, decreased functional use of extremity, pain, deformity, contracture and/or skin breakdown. A physician's examination note, dated 5/3/24, revealed the resident was taken to the operating room on 6/22/23 due to a small bowel obstruction and had lysis (surgical removal) of adhesions (bands of tissue lining the small intestine) to relieve the bowel blockage and alleviate symptoms of abdominal pain and vomiting. A physician's examination note, dated 6/27/24, revealed the resident was in discomfort from his penile injury from his foley catheter. The note documented the resident had an injury to the glans (tip) of the penis with a vertical tear secondary to the foley catheter placement. The note documented the facility would be asked to arrange an outpatient follow-up appointment with (name of provider) urology for evaluation and for the resident to be transported using a gurney. The note documented the resident would be closely monitored and to continue local wound care. A nurse practitioner examination note, dated 7/12/24, documented Resident #9 was assessed and was unable to properly transfer to a wheelchair due to his chronic extremity contractures related to a diagnosis of paraplegia secondary to transverse myelitis. A physician's referral note, dated 7/11/24, documented to refer the resident to (provider name) urology for evaluation of an injury to the glans penis due to foley catheter insertion. The director of nursing (DON) was informed. A weekly summary note, dated 7/18/24, documented the resident was dependent on staff for bed mobility, transfers and dressing. III. Staff interviews The transportation coordinator (TC) was interviewed on 7/24/24 at 10:41 a.m. The TC said she arranged transportation for residents. She said the nursing staff scheduled the appointments and put them on the calendar. She said she then arranged transportation to the appointments through an independent transportation company. The TC said, depending on the resident's needs, sometimes it was a car to transport residents who were able to walk and independently transfer into a car. She said if the resident used a wheelchair, she would arrange for a wheelchair accessible transportation van. The TC said she was aware Resident #9 needed to have a gurney transport, however, the resident's insurance provider would not pay for that type of transportation. The TC said she was aware that the resident had missed two or three appointments because there was no transportation. She said she was told it would cost $700.00 for a gurney transportation and when she asked the NHA if the facility would pay for the resident's transportation he said no. Regional nurse consultant (RNC) #1 was interviewed on 7/24/24 at 10:41 a.m. RNC #1 said the facility should provide transportation regardless of what the resident's insurance provider would pay for. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 7/27/24 at 11:04 a.m. The NHA said he was told by the TC that Resident #9 could be transported in a wheelchair and that the resident's representative said they would attempt to transport the resident in a wheelchair. The NHA said he was not aware that the resident's appointments had been canceled due to the resident's inability to tolerate long periods sitting in a wheelchair. He said the missed appointments had been rescheduled and the facility was seeking gurney transportation to get the resident to his appointment. 41032

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 20287 Based on interviews and record review, 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. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of care, specifically pressure injuries. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) Program policy, last revised February 2020, was provided by the nursing home administrator (NHA) on 7/29/24 at 4:40 p.m. The policy read in pertinent part, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to provide a means to measure current and potential indicators for outcomes of care and quality of life, provide a means to implement performance improvement projects to correct identified negative or problematic indicators and establish systems through which to monitor and evaluate corrective actions. II. Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies and initiate a plan to correct F686 Pressure injuries During the recertification survey on 8/26/21, failure to provide treatment and services for pressure injuries was cited at a G level, actual harm that is not immediate jeopardy, isolated. III. Cross-referenced citations F686 Cross-reference F686 Pressure injuries: The facility failed to implement interventions and treatment to prevent a resident from developing a facility-acquired unstageable pressure injury that evolved into a stage 4 pressure injury which became infected. III. Interviews (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical director (MD) was interviewed on 7/29/24 at 11:15 a.m. The MD said he attended the QAPI meeting monthly. He said pressure injuries were discussed at the QAPI meeting. He said a specialized wound physician followed the residents who had wounds. The MD said he was not aware Resident #5's wounds were infected. Regional nurse consultant (RNC) #2 was interviewed on 7/29/24 at approximately 2:00 p.m. RNC #2 said she came to the facility on ce a week and was available by phone at any time. She said her role was to give support to the director of nursing (DON) and to the facility. She said when she was at the facility, she reviewed audits and provided teaching when needed. She said she needed to get more involved with the residents who had pressure injuries and review the records and the status of the wounds more frequently. The NHA was interviewed on 7/29/24 at approximately 4:00 p.m. The NHA said the QAPI meetings were held monthly. He said the interdisciplinary team (IDT) was involved and would present topics depending on the agenda. He said, based on topics that were discussed in the QAPI meeting, additional committees would be formed. He said resident council, grievances, reports and any happenings in the building were used to identify issues. The NHA said the QAPI team looked for trends and root causes and then put a performance improvement plan in place. The NHA said the facility had a wound physician and an outside consulting company that was involved with the pressure injuries. He said the pressure injuries were discussed in QAPI meetings. He said the appointed wound nurse reported on the injuries. He said there was a performance improvement plan that was developed in regards to pressure injuries, however, he said it did not include goals. The NHA said, at the morning meetings, pressure injuries were discussed with the IDT. He said although they were discussed, it was not an in-depth discussion. He said for the wound program to advance, the facility would have to discuss each pressure wound more fully.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 41032 Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for all staff based on the facility assessment and resident population. Specifically, the facility failed to: -Ensure all direct and non-direct care staff received training in quality assurance and quality improvement (QAPI), compliance and ethics and resident rights; -Ensure all direct and non-direct care staff received training in all components of abuse training including abuse prevention, identification and types of abuse; -Ensure all certified nurse aides (CNA) received at least 12 hours of annual in-service training. Findings include: I. Facility policy and procedure The In-service Training, All Staff policy, dated 2021, was provided by the nursing home administrator (NHA) on 7/28/24 at 9:oo a.m. It read in pertinent part, All staff must participate in initial orientation and annual in-service training. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competencies in the topic areas of the training. Required training topics include the following: -Effective communication with residents and family; -Resident rights and responsibilities; -Preventing abuse, neglect, exploitation, and misappropriation of residence property including activities that constitute abuse neglect exploitation or misappropriation of residential property; -Procedures for reporting incidents of abuse neglect exploitation or misappropriation of resident property; -Dementia Management and Abuse Prevention; -Elements and goals of the facilities QAPI (quality assurance, quality improvement) program; -Infection prevention and control program standards, policies and procedures; (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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Behavioral Health; and, -The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities). II. Record review Staff training records related to QAPI, compliance and ethics, resident rights and abuse prevention and identification were requested from regional nurse consultant (RNC) #1 and the NHA on 7/25/24 at 8:42 p.m. Additionally, the training records of five CNAs were selected at random for review. -The facility was unable to provide documentation that all staff received the required training and no staff had received training on the facility's QAPI program. Cross-reference to F867 for failure to ensure QAPI improvement activities. -The records of the five randomly selected CNAs (#3, #4, #5, #6 and #7) were reviewed and none of the CNAs received all of the required training sessions (all required components of abuse training, QAPI, Compliance and ethics and resident rights) and none had received a total of 12 hours of annual in-service training. -The training records failed to document the training sessions' durations. III. Staff interviews The NHA was interviewed on 7/29/24 at 2:22 p.m. The NHA said the facility had not provided any staff training on the QAPI program but they would get started on planning for the training. The NHA said they had trained all staff on abuse. -However, the abuse training topic was on the topic of elder and dependent adult abuse reporting and not abuse prevention and identification. -Additionally, some staff received the training more than 12 months prior to the survey and had no record of being provided a refresher training on an annual basis The NHA was interviewed again on 7/31/24 in a follow-up regarding the CNA training records. The NHA said the annual CNA training was a bit bare and the facility would be working on getting the CNAs training up-to-date, along with the QAPI training. .