STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065245	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbine West Health & Rehab Facility	940 Worthington Cir Fort Collins, CO 80526

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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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 50219 Based on observation and interviews, the facility failed to post, in a form and manner accessible and understandable to residents, information on how to file a complaint with the State Agency. Specifically, the group interview revealed the facility failed to ensure residents knew where the required posting on how to file a complaint with the State Agency was located and that residents were able to easily access and read the information on the posting. Findings include: I. Resident group interview The resident group interview was conducted on 4/10/24 at 1:10 p.m. with eight residents (#1, #44, #146, #7, #35, #61, #8 and #21) who routinely attended monthly resident council meetings and were deemed interviewable by the facility and assessment. All eight residents said they did not know how to file a complaint with the State Agency and were not aware the information was posted in the facility. Resident #1 said whenever he had a concern and told a certified nurse aide (CNA) about it, the concern was never followed up on by the facility. II. Observation On 4/11/24 at 9:53 a.m. the required posting with the State Agency information on it was observed in the corner of the lobby. The information on how to file a grievance was posted above the eyeline for a resident in a wheelchair and was written in a small font. III. Staff interview The social services director (SSD) was interviewed on 4/11/24 at 9:46 a.m. The SSD was not sure where the State Agency information was posted and said he needed to ask someone. After asking someone, the SSD said the posting was located in the corner of the facility lobby. The SSD said the posting might not be visible to residents, depending on their level of visual impairment, but he said the residents felt comfortable asking staff members for help if they could not see the posting.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to take steps to ensure the 15 residents, including Resident #39, who resided in the secure unit were free from potential sexual abuse by Resident #43. Record review revealed Resident #43 had a documented history of sexually inappropriate behavior toward male residents. Record review and interview revealed the facility failed to take timely steps to minimize the potential risks to other residents related to her behavior. Findings include: I. Facility policy and procedure The Abuse Prevention policy, revised 1/19/23, was received from the nursing home administrator (NHA) on 4/8/24 at 11:34 a.m. It read in pertinent parts: The facility does not condone resident abuse, neglect, exploitation or misappropriation of resident property by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the residents, family members, legal guardians, sponsors, friends, or any other individual. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, or deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Sexual abuse includes but is not limited to, sexual harassment, sexual coercion, or sexual assault. III. Residents A. Resident #43 Resident #43, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), the resident's diagnoses included vascular dementia, anxiety, bilateral age-related macular degeneration (an eye disorder that causes blurred vision or a blind spot), congestive heart failure, chronic respiratory failure, and reduced mobility. The 2/7/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The 10/24/23 care plan identified the resident had dementia with behavioral disturbances. She may make inappropriate statements or gestures towards others. Interventions included administering Aricept and Seroquel, monitoring for adverse side effects, allowing the resident to have as much independence with personal care as safely possible, providing choices, and building a rapport with the resident at the beginning of the shift to facilitate trust. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident #39 Resident #39, age greater than 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses include Alzheimer's disease, reduced mobility, anxiety disorder, repeated falls, and unsteadiness on feet. The 1/31/24 MDS assessment revealed he did not have a BIMS assessment completed due to severe cognitive impairment. The resident's 7/10/23 care plan revealed he had impaired cognitive status related to Alzheimer's dementia. Interventions included reminding the resident of the location of his room, time for meals, etc. The 10/17/23 care plan revealed the resident had cognitive loss and communication deficits related to dementia. He may not understand what was said to him and was unable to make his needs known. Interventions included monitoring for signs and symptoms of restlessness. The 11/16/23 care plan revealed the resident had a diagnosis of anxiety disorder. Interventions included administering Gabapentin and Paxil as ordered, monitoring for adverse effects, and notifying the provider. Also, to provide emotional support and if the resident was irritable, ask for sources of discomfort and attempt to remedy. III. Incident of potential sexual abuse Interviews revealed an incident of potential sexual abuse involving Resident #43 and Resident #39. The incident was also documented in the facility's investigation conducted during the survey on 4/10/24, eight days after the incident occurred. A. The social services director (SSD), in an interview on 4/9/24 at 2:02 p.m., said Resident #43 had placed male Resident #39's hand underneath her shirt and his hand touched her breast. The SSD said her immediate intervention was to tell Resident #43 that Resident #39 was married. Resident #43 then removed her (and Resident #39's) hand. The SSD said she told the nursing home administrator (NHA) what happened and the NHA said the incident was not reportable. She did not remember the exact date but said it was in the past two weeks. B. A review of the facility investigation of the incident conducted during the survey and dated 4/10/24, revealed the incident occurred on 4/2/24. The facility investigation read in part: -On 4/2/24, the social services director (SSD) noted the hand of Resident #39, who had a diagnosis of Alzheimer's disease, was placed on the breast of a female resident, Resident #43, by the female resident. Resident #39 did not move his hand when it was upon her breast and did not appear to be in any distress. The SSD sat in between both residents and took Resident #39's hand away from the female resident's breast. The SSD told the female resident (Resident #43) that Resident #39 was married and his wife would not appreciate what she did. Staff sat the female resident at another table. The SSD asked Resident #39 if he was ok, to which he responded yes. Upon further interviewing, the SSD also asked Resident #39 if a situation like this was to happen again would he be upset, and he said no. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/3/24 at 10:04 a.m., the SSD reported the incident to the NHA. The NHA asked the SSD to follow up the next morning to assess if there were any changes in Resident #39's previous response. The NHA said that based on Resident #39 response and lack of any nonverbal expressions that would indicate distress, an incident report was not appropriate and their interaction was consensual. The facility investigation further read: - On 4/2/24 and 4/3/24, Resident #39 was interviewed by the SSD. Resident #39 did not have a brief interview for mental status (BIMS) assessment completed due to severe cognitive impairment. He was asked if he remembered the incident and he said no. He was asked if the scenario were to happen to him if he would be upset and he said no. The SSD said that based on this interview, she concluded it was not a reportable incident because he did not recall it. He was not in distress after this interaction. -On 4/10/24 at 2:00 p.m., Resident #43 was re-interviewed. Her BIMS assessment was three out of 15 which indicated she had severe cognitive impairment. She reported she was happy. She was sad, did not feel safe, and did not enjoy living at the facility because My babies aren't here. She said she likes the residents in the unit and she did not recall the incident. -On 4/10/24 at 2:00 p.m., Resident #39 was re-interviewed. His BIMS assessment was not completed due to severe cognitive impairment. He reported he was happy and enjoyed living at the facility. He was not sad. He did not respond when asked if he felt safe and if he got along with the residents. He did not recall the incident. C. On 4/9/24 at 2:30 p.m., there was no documentation that the facility had reported the incident to the state as potential sexual abuse. IV. Facility failures A. Facility failure to respond to respond to Resident #43's inappropriate behaviors before 4/2/24. Record review revealed facility knowledge of Resident #43's inappropriate sexual behavior before 4/2/24. -A social services progress note on 2/29/24 by the SSD revealed the resident touched another male resident in the groin area. A certified nurse aide (CNA) tried to take the resident's hand away from the male resident. The SSD told the resident that the man was married and his wife would not appreciate that. Resident #43 asked if the SSD was married to the male resident, she said yes and the resident let go of his hand. The CNA then told the SSD that the resident kissed the male resident earlier. The male resident did not appear to be in any distress. The resident was moved away from the male resident and staff encouraged the resident to eat in her room that evening. -Further record review revealed the facility opened an expression of need (EON) event, a form to document resident behaviors, from 3/1/24 through 3/10/24. A review of the EON revealed it was opened to document resident sexual comments or actions. However, there was no evidence Resident #43's care plan was revised to identify and address the potential risk of abuse to other residents related to Resident #43's sexual comments or actions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Facility failure address promptly and comprehensively the incident on 4/2/24. A review of the facility investigation of the incident conducted during the survey and dated 4/10/24 (see above), revealed the SSD did not report the incident involving Resident #43 and #39 until the next day. While the facility investigation documented steps taken by the facility, there was no documentation of these steps until 4/10/24 during the survey. Further, while the facility investigation indicated neither Resident #43 nor #39 recalled, was upset, or remembered the incident on 4/2/24, there was insufficient documentation that the residents'ability to consent to sexual contact was thoroughly assessed. -There was no indication Resident #39 understood the scenario posed by the SSD and the consequences of his answer when asked if the scenario described would upset him. -There was no indication Resident #39 understood the consequences of his answer to the NHA when asked if the incident with Resident #43 was consensual and he said yes, even though this was a factor, in part, in the determination that the incident was not considered potential abuse. A review of Resident #43 and #39's progress notes revealed no documentation regarding the incident on 4/2/24 and no evidence of a plan to monitor the residents'well-being following the incident. Finally, although the 4/2/24 incident represented a second incident of inappropriate sexual behavior toward a male resident, there was no evidence Resident #43's care plan was revised to identify and address the potential risk of abuse to other residents related to Resident #43's sexual comments or actions. 3. Facility failures after the incident 4/2/24 Record review revealed documentation that Resident #43 continued to exhibit inappropriate sexual behavior after the incident on 4/2/24. -Another EON event was opened on 4/3/24 to document any sexually inappropriate actions or language. A social services progress note also dated 4/3/24, revealed the resident using sexually inappropriate language and actions toward other male residents and male staff. She asked the staff if they would like to go to bed and would like to cuddle and kiss. The note read that although this was not a new expression, it seemed to increase, the event opened to monitor. -A nurse progress note on 4/4/24 revealed the resident asked the nurse to go to bed with her. It was not a new expression. Interventions included a calm environment, avoiding overstimulation, calm, slow understandable approach, redirection, distraction, safety of resident, ensure comfort. The interventions were effective. -A nurse progress note on 4/5/24 revealed the resident asked multiple staff members to go to bed with her. She asked another resident to go to bed with her. The CNA relayed to the nurse that the resident was hallucinating this evening, saw a boy/male in her room, and did not want the CNA to leave her alone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A nurse progress note on 4/7/24 revealed the resident was agitated and tried to touch a male's resident personal area. The male resident was moved away from the area where the resident was sitting. The resident started to yell and asked to bring the resident back. The resident was redirected to watch television in her room in an effort to calm her down. -A nurse progress note on 4/8/24 revealed the resident asked a male resident to go to bed with her. Interventions included music or television, a calm environment and avoiding overstimulation, redirection, distraction, and the safety of the resident maintained. The interventions were somewhat effective. Although the nurse progress notes referenced interventions to address Resident #43's inappropriate behaviors which were sometimes effective, these interventions were not placed on the resident's care plan for consistent implementation until 4/8/24, during the survey. 4. Interviews with staff revealed not all staff were aware of planned interventions to ensure they were implemented consistently. A care plan, initiated on 4/8/24, identified that the resident made sexual comments or approaches toward staff and other residents at times. Interventions included if the resident experienced hypersexual behaviors or actions, try to remove the resident from the staff or resident or remove the resident from crowded areas with male residents, behavior management team to review as needed and according to facility protocol, and staff to have heightened awareness of resident's whereabouts. If the resident approached a male resident in the hall or dining room, observe and redirect if she attempts physical contact with the resident. CNA #5, interviewed on 4/9/24 at 4:52 p.m., said he knew to be careful with Resident #43 because she could be handsy with someone. He said when she exhibited these behaviors, he would try to distract and redirect her. He said her behaviors were consistent throughout the day. He said she varied on how handsy she would be and said he had not seen her act like that with male residents. -The CNA did not mention for staff to have heightened awareness of the resident's whereabouts. Licensed practical nurse (LPN) #2, interviewed on 4/9/24 at 4:50 p.m., said he was familiar with Resident #43. He said the resident exhibited sexual behaviors to males. He said she bounced between being funny and sweet to being super grabby with male residents. She made comments like take off your pants, come to my bed, and come to my room. He said redirection helped the resident. If three male residents were sitting at a table, he would redirect the resident to sit in a different direction. He said out of sight out of mind helped the resident's behavior. -The LPN did not mention for staff to have heightened awareness of the resident's whereabouts. Registered nurse (RN) #5, interviewed on 4/9/24 at 4:55 p.m., said she did not receive training on how to handle Resident #43. She used redirection when the resident had behaviors. The RN said when the resident exhibited behaviors she would make a joke to redirect her. If her behavior affected other residents, RN #5 would intervene and would redirect her. -The RN did not mention for staff to have heightened awareness of the resident's whereabouts. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Additional steps taken by the facility during the survey and facility follow-up after the survey regarding the facility's determination that the incident on 4/2/24 did not represent potential abuse as it was consensual. The NHA was interviewed on 4/10/24 at 9:17 a.m. She said Resident #43 had a one-on-one sitter as of 4/10/24 and for the foreseeable future. She said Resident #43's care plan was updated with interventions that worked for the resident. Resident #43's provider visited on 4/10/24 to review her medications. The NHA said the provider told her that Sertraline could cause an increase in sexual behaviors. The NHA also reported the incident to the state. She said it was better to err on the side of caution. She said she contacted the ombudsman to conduct additional training. The NHA provided a copy of an in-service training class for one-on-one care for Resident #43 on 4/10/24 at 4:00 p.m. The training class took place on 4/10/24. It revealed good interventions were transitional conversations, coffee or beverage of choice, talking about her sons, offering meaningful activities, offering baby doll, offer therapy or other comfort items. The NHA emailed the following statement on 4/12/24 at 8:41 a.m. explaining that review of the incident which occurred promptly as well as a review of the regulations, the incident was determined to not meet reportable criteria as the element for Consent Not Given was not present; the alleged victim in this situation engaged in the act with the alleged perpetrator with no signs of distress or action to stop the act. The facility acted in good faith and timely to review and respond to this incident. The medical director (MD) provided a letter on 4/12/24 that indicated it is misleading to assume that dementia residents could not participate in their decision-making as they routinely do in a long-term care setting and based on the SSD's report of the incident, Resident #39 did not withdraw from Resident #43's attempt at intimate touch. He did not verbalize no and did not physically push away. The staff had to physically separate him as he did not choose to do so on his own. The MD said Resident #39 showed in the past that he is capable of verbalizing needs and dislikes. He demonstrated this by prior refusals of care in the setting of intimate personal care delivered by facility staff. The resident did not express concern or distress with the incident. He said he was okay with similar engagement with female residents in the future. The MD said Resident #43 had advanced dementia and she did not understand her expressions were inappropriate, especially in public space, and that her verbal expressions were not welcomed by male staff. -However, the facility failed to consider and address Resident #43's known inappropriate behaviors before and after the 4/2/24 incident to ensure the protection of residents in the secure unit from future potential sexual abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to ensure the comprehensive care plan was reviewed and revised timely to include the instructions needed to provide effective and person-centered care for one (#56) of six residents out of 36 sample residents. Specifically, the facility failed to revise Resident #56's care plan to address the resident's pattern of repeated refusals of three physician ordered pain medications. I. Resident #56 A. Resident status Resident #56, age 78, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, Parkinson's disease, psychotic disturbance, mood disturbance, anxiety, hallucinations, post traumatic stress disorder, depression, pain in right and left knee, stiffness of left knee and chronic pain syndrome. The 1/2/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment indicated the resident had moderate pain frequently which interfered with her day to day activities. B. Record review The pain risk care plan, revised 4/5/24, revealed the resident was at risk due to her knee pain related to arthritis, headaches, jaw pain, and diagnoses of chronic pain syndrome neurologia. The resident was able to express her pain to staff. She voiced complaints of muscle spasms. Interventions included administering pain medications as ordered and monitoring effects,pain medications included acetaminophen, biofreeze gel and gabapentin. -The pain care plan failed to document Resident #56 frequently refused her pain medications or interventions to try to get her to take her medications. The April 2024 CPO revealed the following physician orders: Acetaminophen 500 mg (milligrams). Take two tablets three times a day for arthritic pain. Start date 2/23/24. Biofreeze gel 4%. Apply a thin layer to the right knee three times a day for arthritic pain. Start date 10/27/22. Gabapentin 400 mg. Take one capsule three times a day for pain. Start date 6/1/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56's January 2024 medication administration record (MAR) revealed the following: Biofreeze gel 4% was not administered due to the resident's refusal on: -1/5/24 at 7:00 a.m. and 12:00 p.m; -1/8/24 at 12:00 p.m; -1/9/24 at 7:00 a.m., 12:00 p.m. and 5:00 p.m; -1/13/24 at 12:00 p.m; -1/14/24 at 5:00 p.m; -1/18/24 at 7:00 a.m., 12:00 p.m. and 5:00 p.m; -1/21/24 at 12:00 p.m; -1/26/24 at 12:00 p.m; and, -1/31/24 at 7:00 a.m. Resident #56's February 2024 MAR revealed the following: Biofreeze gel 4% was not administered due to the resident's refusal on: -2/8/24 at 7:00 a.m. and 12:00 p.m; -2/10/24 at 7:00 a.m. and 12:00 p.m; -2/19/24 at 7:00 a.m; -2/22/24 at 7:00 a.m. and 12:00 p.m; and, -2/23/24 at 12:00 p.m. Resident #56's March 2024 MAR revealed the following: Acetaminophen 500 mg, two tablets was not administered due to the resident's refusal on: -3/1/24 at 5:00 p.m; -3/8/24 at 5:00 p.m; -3/16/24 at 5:00 p.m; -3/17/24 at 6:30 a.m; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/20/24 at 5:00 p.m; and, -3/25/24 at 12:00 p.m. Biofreeze gel 4% was not administered due to the resident's refusal on: -3/1/24 at 7:00 a.m. and 5:00 p.m -3/6/24 at 7:00 a.m. and 5:00 p.m; -3/8/24 at 5:00 p.m; -3/13/24 at 5:00 p.m; -3/14/24 at 5:00 p.m; -3/16/24 at 5:00 p.m; -3/17/24 at 7:00 a.m. and 5:00 p.m; -3/19/24 at 5:00 p.m; -3/20/24 at 5:00 p.m; -3/21/24 at 5:00 p.m; -3/22/24 at 7:00 a.m. and 5:00 p.m; -3/25/24 at 12:00 p.m. and 5:00 p.m; -3/26/24 at 5:00 p.m; and, -3/31/24 at 5:00 p.m. Gabapentin 400 mg was not administered due to the resident's refusal on: -3/8/24 at 5:00 p.m; -3/16/24 at 5:00 p.m; -3/17/24 at 7:00 a.m; and, -3/25/24 at 12:00 p.m. Resident #56's April 2024 MAR revealed the following: Acetaminophen 500 mg, two tablets was not administered due to the resident's refusal on: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/6/24 at 12:00 p.m; and, -4/7/24 at 6:30 a.m. Biofreeze gel 4% was not administered due to the resident's refusal on: -4/2/24 at 12:00 p.m; -4/3/24 at 5:00 p.m; -4/4/24 at 7:00 a.m. and 12:00 p.m; -4/5/24 at 5:00 p.m; -4/6/24 at 12:00 p.m; and, -4/7/24 at 7:00 a.m. Gabapentin 400 mg was not administered due to the resident's refusal on: -4/6/24 at 12:00 p.m; and, -4/7/24 at 7:00 a.m. -There was no documentation in Resident #56's electronic medical record (EMR) to indicate the facility had attempted to address the resident's repeated pattern of pain medication refusals or update the resident's care plan. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/11/24 at 11:36 a.m. LPN #1 said if a resident refused medications it was the resident's right to refuse. He said he tried to educate residents why they should take their medication. He said there was a trend of medication refusals, the provider and family should be notified. He said the provider should be notified because the provider could see what other medication options were available for the resident. LPN #1 said the residents ' family should be notified because they might know other ways that helped get the resident take the medication. LPN #1 said he was familiar with Resident #56 and she never refused medications from him. He said he built a rapport with her and thought she did better with male nurses and aides. LPN #1 said it was important to figure out how to approach Resident #56 so she did not refuse her medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse manager (NM) #1 was interviewed on 4/11/24 at 11:03 a.m. NM #1 said every resident had a right to refuse medications. She said nurses should educate the residents why they should take the medication. She said the nurse should reattempt a couple times before the nurse documented the refusal in a progress note. NM #1 said if a resident refused medications for a couple of days the facility should try to see what was going on and if there was something that triggered the refusals. She said she would collaborate with the provider or hospice. She said Resident #56's refusals could be due to her receiving too many medications at once. She said the family should be notified when there was a trend and asked for input on what might work to ensure the resident took their medications NM #1 was interviewed again on 4/11/24 at 12:19 p.m. NM #1 said she reviewed Resident #56's chart and she saw the resident had multiple refusals of her pain medications. She said the Biofreeze gel was cold to the touch which could be why Resident #56 was refusing the medication. She said she would talk with the nurse to find out what might be causing the resident to refuse her medications. NM #1 said she saw a trend with a specific nurse who documented the resident refused medications frequently. She said this might be a training opportunity for that specific nurse on how to approach the resident and what to do when the resident refused medications. The assistant director of nursing (ADON) was interviewed on 4/11/24 at 1:01 p.m. The ADON said if a resident refused medications the nurse should reapproach a couple times. He said if the resident still refused, the nurse should go to the charge nurse because they might have tips on how to approach the resident for medication administration. He said if there was a trend, the provider and family should be notified. An event in the resident's electronic medical chart should be opened and the trend should be discussed in the morning nurse's meeting to identify a plan to address the refusals. The ADON said he was familiar with Resident #56. He said he knew she refused medications but did not know or could not remember why she refused.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to ensure one (#30) of four residents reviewed for pressure injuries out of 36 sample residents received care consistent with professional standards of practice to prevent pressure injuries. Resident #30 was admitted on [DATE] for long term care. At the time of the admission, the resident was identified as being at risk for developing pressure injuries. Upon admission, the resident's skin was intact and she did not have any pressure injuries. Resident #30 attended dialysis three times a week. On 10/7/23, a nurse documented Resident #30 developed a deep tissue injury (DTI) on her right heel. Preventative measures to protect the resident's heels were not implemented until after the development of the DTI on 10/7/23. On 10/12/23, the wound care physician classified the resident's wound as an unstageable pressure injury. Due to the facility's failure to implement effective pressure injury prevention interventions in a timely manner, Resident #30 developed a facility-acquired DTI to her right heel. Findings include: I. Professional reference 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 4/17/24, 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 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown 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. II. Facility policy and procedure The Skin Protection and Wound Prevention policy, revised 6/29/23, was received from the nursing home administrator (NHA) on 4/11/24 at 1:45 p.m. It read in pertinent part, Most residents admitted to the facility are considered at risk for developing wounds, although the level of risk may vary. Staff at the facility take an aggressive approach to wound prevention and will implement the following protocol upon admission on all residents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Procedure: skin assessments will be completed upon admission, within one to two weeks of admission, quarterly, and with a significant change of condition. Nursing assessment of skin condition will be completed at least weekly and documented in medical record. Care of residents with decreased mobility includes: off-loading heels with a pillow if resident is unable to reposition their lower extremities, turning or repositioning at least every two hours or more frequently, use of pillows or other positioning device to keep bony prominences from direct contact with one another. All residents with braces, splints, casts, or other mechanical devices will have skin closely monitored for breakdown. III. Resident #30 A. Resident status Resident #30, age 73, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included diabetes mellitus (high blood sugar), end stage kidney disease (kidneys can no longer support body's needs) with hemodialysis (process where a machine filters and cleans the body's blood) and dementia. According to the 4/6/24 minimum data set (MDS) assessment, Resident #30 was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. She required touching assistance for rolling left to right and most transfers. She required substantial/maximal assistance for lower body dressing and putting on/taking off footwear. The assessment documented the resident was at risk of developing pressure ulcers and one unstageable pressure ulcer due to coverage of the wound bed with slough (soft, dead tissue, usually cream or yellow in color) and/or eschar (firm, dry dead tissue, usually black in color) which was not present upon admission. According to the 9/24/23 admission MDS assessment, the resident was at risk of developing pressure injuries but had no current pressure injuries present at admission. B. Wound observation and interview On 4/9/24 at 3:56 p.m. a wound observation was completed in the presence of registered nurse (RN) #1. Resident #30 was positioned on the recliner with heels floating off the recliner. The resident was wearing soft blue foam booties. With consent from the resident, RN #1 removed the dressing to the resident's right heel. Moderate yellow discharge was observed on the dressing. The wound on the resident's heel was oblong in shape extending to both sides of the heel. The wound bed was pink in color with multiple areas of yellow tissue (slough) obstructing the wound. RN #1 said there was some yellow slough covering the wound bed. She said the pressure injury developed after admission and she believed it was from the resident sitting in the dialysis chair for extended periods of time without wearing pressure reducing boots. C. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 9/18/23 admission nursing assessment documented this resident's only skin conditions on admission included a right lower extremity surgical wound and bilateral (right and left sides) lower extremities were dry and scaly. The skin integrity care plan, initiated 9/19/23 and revised 4/9/24, identified Resident #30 was at risk for skin breakdown due to age, limited mobility, occasional incontinence and diagnosis of diabetes. Interventions included encouraging the resident to wear long sleeves/long pants, use a pressure reducing mattress, use pillows or off-loading devices to relieve pressure on heels, use a cushion in a chair, keep linens clean, dry and wrinkle free, reposition the resident, encourage physical activity, use lift device to avoid shearing, assess and monitor risk factors, apply lotion to lower extremities, keep resident clean and dry, and encourage adequate intake of nutritional foods. -However, review of the September 2023 and October 2023 treatment administration records (TAR) revealed there was no documentation to indicate the resident had heel protection in place and staff were monitoring for the heel protection until 10/16/23, after the development of the right heel wound. A progress note documented by an RN on 10/7/23 revealed there was a new deep tissue injury (DTI) to the resident's right heel. The note documented new interventions for the wound included a dressing and heel protector boots. The wound care registered nurse (WCRN) documented an initial note on 10/9/23. It revealed the right heel had eschar surrounded by slough and maceration (soft skin, when skin is in contact with moisture for too long). A wound care physician note from 10/12/23 documented the resident was being evaluated for an unstageable pressure injury on the right heel. The injury obscured full thickness and tissue loss, had moderate serous (clear, watery plasma) drainage and 100% eschar. Orders included right heel wound care orders, specialty mattress, offloading heels, wheelchair cushion, nutritional supplements, turn and repositioning resident and monitor for signs of infection. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/9/24 at 1:49 p.m. CNA #1 said Resident #30 required assistance of one person for walking, transferring, showering and repositioning. She said she helped the resident put off-loading boots on before she went to dialysis, when she was in bed and up in her wheelchair. RN #2 was interviewed on 4/9/24 at 2:10 p.m. RN #2 said the resident required one person to assist her for care. She said the resident wore pressure reducing boots to dialysis, when she was seated in her wheelchair and when she was in bed. She said the WCRN was responsible for her right heel wound since it was a pressure injury but RN #2 said she would replace the dressing as needed if the WCRN was not in the building. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The WCRN was interviewed on 4/10/24 at 3:00 p.m. The WCRN said she saw the resident for the first time once the right heel wound had already developed on 10/9/23. She said the first time she saw the wound there was slough and eschar. She said she notified the wound care physician, painted the wound with betadine, elevated the resident's legs, put pressure off-loading boots on both feet and encouraged the resident not to wear shoes. She said the wound was unstageable. She said on 10/10/23, she noticed the wound had a foul odor, the resident's pain was worse, and there was more drainage from the wound. The resident was put on antibiotics for possible infection. She said the resident would have benefited from elevating her legs and wearing the pressure off-loading boots upon admission. The WCRN said she had not participated in the admission of Resident #30 and therefore it was the responsibility of the admitting nurse to implement any preventive measures upon admission. She said she provided care to the residents in the facility only after they developed wounds. The wound care physician (WCP) was interviewed on 4/11/24 at 10:00 a.m. The WCP said Resident #30 had an unstageable pressure ulcer to her right heel when she began seeing the resident for wound care. She said if interventions, such as offloading the heels and elevating legs on admission had been done, the wound would have likely been prevented. The assistant director of nursing (ADON) was interviewed on 4/11/24 at 2:15 p.m. The ADON said it was likely Resident #30 developed the pressure injury on her heel by sitting for a long time in dialysis. He said the protective booties were not implemented until after the development of the wound. He said since it likely occurred at the dialysis clinic, it was beyond the facility's control to implement any measures while resident at the dialysis. He said the facility did communicate with dialysis prior to every session of the dialysis and could have implemented protective booties for the resident prior to her visits to dialysis.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, interviews and record review, the facility failed to ensure residents received person-centered dementia care that met their needs for one (#43) of five residents reviewed for dementia care out of 36 sample residents. Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #43 in order to provide the resident with her highest practicable quality of life and care. Findings include: I. Facility policy A dementia policy was requested from the facility on 4/11/24, however, one was not provided A Dementia Tools document, which was undated, was received from the nursing home administrator (NHA) on 4/11/24 at 12:58 p.m. It read in pertinent part: Meal tips - food and fluids. Let them eat what sounds good, even if it was not good for them. A dementia training document, which was undated, was received from the NHA on 4/11/24 at 12:58 p.m. It read in pertinent part: Provide remarkable individualized care. Build meaningful relationships that enrich lives in a stimulating and supportive environment. The Expression of Need Management policy, revised 3/7/24, was received from the NHA on 4/11/24 at 12:58 p.m. It read in pertinent part: Necessary care and services will be provided with a person-centered approach that reflects the resident's goals while maximizing the resident's quality of life. II. Resident #43 A. Resident status Resident #43, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included vascular dementia, anxiety, bilateral age related macular degeneration (eye disorder that causes blurred vision or a blind spot), congestive heart failure, chronic respiratory failure and reduced mobility. The 2/7/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment indicated the resident wandered daily and her behavior remained the same from the previous assessment. The resident did not refuse care. B. Resident representative interview (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative was interviewed on 4/8/24 at 2:09 p.m. He said that Resident #43 struggled emotionally and he wished he understood the resident. He said her dementia caused her to be excited. He said she had lost her independence which caused her some frustration. He thought Resident #43 wished she had free range mobility and that her friends visited her. He said the secured unit tempered her ability to move as she wished, however, he said it was important for the facility to keep a close eye on her because she wandered and said she wanted to go outside to her children and grandchildren. C. Observations On 4/9/24, during a continuous observation beginning at 10:57 a.m and ending at 11:57 a.m., the following observations were made: At 10:57 a.m. Resident #43 was sitting in the community area of the secured unit. She sat at a table by herself facing a wall of cabinets and a small refrigerator. She had animal graham crackers and a cup of liquid. -There was no staff interacting with her. At 10:59 a.m. the resident asked for food. An unidentified staff member reminded the resident she had crackers on the table. Resident #43 said she wanted something other than crackers. The unidentified staff member offered yogurt, pudding or applesauce. The resident said she wanted all of the options. -The unidentified staff member gave the resident yogurt, but did not provide her with the other two options that had been mentioned. -The unidentified staff member made no attempt to engage the resident in conversation or provide any other interaction other than to give the resident yogurt. At 11:05 a.m., another resident was escorted to the same table as Resident #43. At 11:09 a.m. an unidentified nurse walked by and Resident #43 said she wanted food. The nurse said lunch was coming. -The nurse did not interact further with Resident #43 or provide the resident with any other type of activity in an attempt to distract the resident from her repetitive requests for food. At 11:15 a.m. Resident #43 said she wanted coffee. The other resident at her table agreed and said they needed coffee. At 11:20 a.m. Resident #43 asked about food again. -None of the staff who were nearby getting drinks for residents acknowledged Resident #43's question about food. At 11:26 a.m. Resident #43 again asked about lunch. Certified nurse aide (CNA #1) said lunch was coming in four minutes. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA #1 did not interact further with Resident #43 or provide the resident with any other type of activity in an attempt to distract the resident from her repetitive requests for food. At 11:28 a.m. Resident #43 asked the other resident at her table about food. The other resident said she had to wait. At 11:30 a.m. Resident #43 told the other resident at her table there were two minutes until lunch and she wondered what was for lunch. At 11:41 a.m. the other resident's lunch arrived at the table. At 11:42 a.m. the other resident told an unidentified staff member to give Resident #43 her lunch. At 11:44 a.m. Resident #43's lunch arrived. At 11:53 a.m. Resident #43 said she wanted dessert. -None of the staff acknowledged the resident's request for dessert. On 4/10/24, during a continuous observation beginning at 2:40 p.m and ending at 3:40 p.m., the following observations were made: Resident #43 had a one-to-one staff member sitting next to her in the community room in the secured unit. Resident #43 was in a wheelchair. -At 2:40 p.m. Resident #43 said she wanted breakfast. She was near several unidentified staff members, including the one-to-one staff member. One unidentified staff member asked her what she wanted besides breakfast because the kitchen was closed. Another staff member told her the kitchen was closed and they did not have breakfast. -Neither of the unidentified staff members made an attempt to get Resident #43 something to eat. At 2:53 p.m. the resident again asked for breakfast. The one-to-one staff member told her what time it was and that dinner was soon. -The one-to-one staff member did not attempt to get the resident something to eat or engage her in any type of meaningful activity to distract her from her repeated request for breakfast. From 2:53 p.m. until 3:00 p.m. the one-to-one staff member pushed Resident #43 up and down the hallway of the secure unit in her wheelchair in an attempt to distract the resident. At 3:00 p.m. the one-to-one staff member returned to the community room with Resident #43. At 3:03 p.m. Resident #43 asked when she could eat. The one-to-one staff member said it was a couple hours until dinner. The resident said she did not want dinner, she wanted breakfast. The staff member said let's go to your room and see what was there. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The one-to-one staff member did not offer Resident #43 anything to eat or attempt to engage the resident in any type of meaningful activity to distract her from her repeated request for breakfast. -At 3:05 p.m. the one-to-one staff member asked CNA #2 where snacks were located. CNA #2 told her where the snacks were. -The one-to-one staff member did not offer the resident any snacks despite having just been told where the snacks were located. -From 3:05 p.m. to 3:40 p.m. the one-to-one staff member proceeded to push Resident #43 up and down the hallway of the secure unit. During the 35 minute timeframe, Resident #43 said four different times that she wanted to get out of here (the secure unit). One time she was asked where she wanted to go and she pointed to the door to leave the secure unit. -The one-to-one staff member did not attempt to interact with or engage Resident #43 in a more meaningful activity than being pushed up and down the hallway of the secure unit. D. Record review The 10/24/23 dementia care plan identified the resident had dementia with behavioral disturbances. Interventions included administering aricept and seroquel and monitoring for adverse side effects, allowing the resident to have as much independence with personal care as safely possible, providing choices and building a rapport with the resident at the beginning of the shift to facilitate trust. -The care plan failed to include the resident's repetitive requests for food, especially breakfast, or any interventions to address the resident's need. The 10/19/23 activities care plan revealed the resident was pleasant and engaged in conversation easily. Barrier to leisure activity was tolerance. Interventions included offering one on one visits for increased social interaction, inviting the resident to activities of interest, staff to introduce resident to other residents during group activities, invite theresident to spiritual programs, set up independent activities as desired and staff to refocus on tasks at hand when distracted. The 3/11/24 care plan identified the resident was at risk for wandering and exit seeking. Interventions included developing a plan of care and recommendations in caring for the resident, maintaining door closures, frequent rounding to ensure the resident was in the facility, providing redirection as appropriate and determining reasons and triggers for wandering. Review of Resident #43's electronic medical record (EMR) revealed the following progress notes: On 2/7/24, the nurse progress note said the resident was shouting and calling out asking for staff to stay with her prior to dinner. On 2/8/24, the nurse progress note said the resident called out to staff, needed company and wanted to talk. The resident thought another resident was her boyfriend and she wanted to feed him. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/9/24, the nurse progress note revealed Resident #43 did not feel safe in the room alone. She was brought to the community room. She felt safer with other people around her. She was put into bed and the resident reported she was very anxious and wanted a staff member to stay with her until she fell asleep. Resident #43 calmed down and fell asleep. On 2/14/24, the social worker's progress note revealed the resident had moments of sadness. On 4/5/24, the nurse progress note revealed the resident asked another resident to go to bed with her. Resident was hallucinating. She saw a boy/male in her room and did not want the staff to leave her alone. The resident talked about dying. III. Staff interviews The nurse manager (NM) #1 was interviewed on 4/11/24 at 11:03 a.m. NM #1 said if a resident had dementia and they asked for food, the staff should give them food. She said if a resident said they were hungry, the staff should not withhold a snack. She said it was important to offer food with dementia residents because it was hard to determine if the resident's satiety (fullness) was reached with the meals provided. NM #1 said she was familiar with Resident #43. She said she used to be the night nurse for the unit Resident #43 lived in. She said if a resident was hungry, she would not withhold a snack. She said she was not aware Resident #43 asked for meals and snacks and that staff said the kitchen was closed and it was not breakfast time and did not offer snacks. She said she would educate the staff. The assistant director of nursing (ADON) and corporate nurse consultant (CNC) #2 were interviewed on 4/11/24 at 1:01 p.m. The ADON and CNC #2 said they were not familiar with Resident #43. The ADON said snacks should be offered to a resident regardless if the resident recently ate something. The resident might have been hungry and the staff should have found a snack. CNC #2 said it was important to offer a resident food that was specific to what they were asking for. If a resident asked for breakfast the staff should offer some breakfast food. CNC #2 said it was not effective telling a resident with dementia that it was not time for breakfast or dinner. CNC #2 said residents with dementia were hard to redirect and if the resident was focusing on food that was the subject of the moment for the resident. CNC #2 said maybe the resident was hungry. The ADON and CNC #2 said they needed to work to train the staff on dementia care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interview, the facility failed to ensure that residents were free of unnecessary psychotropic medications for one (# 66) of five residents reviewed for unnecessary medications out of 36 sample residents. Specifically, the facility failed to track and monitor behaviors for Resident #66 who was on four different psychotropic medications. Findings include: I. Facility policy The Psychotropic Medication policy, revised February 2024, was provided by the nursing home administrator (NHA) on 4/11/24. It documented in pertinent part, An event will be opened to document target symptoms prior to initiation of antipsychotics and will remain open until the resident stabilizes as determined by IDT (interdisciplinary team). Residents are continually monitored for adverse side effects. If noted, an event will be opened and the provider will be notified. Residents taking antidepressant may have target symptoms monitored as recommended by the IDT. If a new hypnotic medication is ordered or recommended, the IDT will open an event to determine the sleep patterns of the resident, and review with consideration on non-medication based approaches to encourage the resident's sleep. II. Resident status Resident #66, age above 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance and depression. The 2/28/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status score (BIMS) score of nine out of 15. The assessment indicated the resident did not display or feel little interest or pleasure in doing things and was not feeling down, depressed or hopeless. He did not display any signs of social isolation. The assessment indicated the resident was not physically or verbally aggressive towards others and he did not reject the care. The assessment indicated Resident #66 was receiving antipsychotic and antidepressant medications. III. Record review (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for psychotropic medications, initiated 1/15/24 and revised 3/11/24, documented the resident was at risk for side effects related to the use of antidepressant medications. Interventions included administering mirtazapine (an antidepressant medication), sertraline (an antidepressant medication) and trazodone (an antidepressant medication) as ordered, monitoring for potential side effects such as headache, tremor, dizziness, insomnia, somnolence, fatigue or allergic reactions and notifying the physician if appropriate. The care plan for cognition, initiated 2/29/24 and revised 3/6/24, revealed the resident had impaired cognitive status related to diagnosis of dementia. Interventions included to provide assistance and verbal cues with activities of daily living (ADL) as needed. -The care plan did not mention the resident's use of psychotropic medication for dementia and specific behaviors the resident displayed. The April 2024 CPO documented Resident #66 was receiving the following medications: Mirtazapine tablet 15 milligrams (mg) orally at bedtime for depression. Start date 2/28/24. Olanzapine (an antipsychotic medication) tablet 2.5 mg orally twice a day for dementia with associated behavior. Start date 2/28/24. -The physician's order did not indicate what associated behavior the medication was used for. Sertraline tablet 200 mg orally, once in the morning, for depression. Start date 2/28/24. Trazodone tablet 25 mg orally at bedtime. Start date 3/8/24. -There was no diagnosis documented for the use of the medication. -The April 2024 CPO did not include daily monitoring for side effects of the psychotropic medications and/or monitoring of targeted behavior related to the use of the medications. -Review of Resident #66's progress notes revealed no documented behaviors. -Review of Resident #66's monitoring events demonstrated no active events for the documentation of targeted behaviors for psychotropic medications. IV. Staff interviews The social services director (SSD) was interviewed on 4/11/24 at 11:30 a.m. The SSD said he participated in psychotropic review meetings but he did not recall discussing any specifics about Resident #66's medications. He was not sure why the resident was on three different antidepressants. The SSD was interviewed again on 4/11/24 at 12:15 p.m. The SSD said he clarified medications with the resident's physician and trazodone was administered for insomnia, not depression. He said he was still uncertain why the resident was on two other antidepressants and he was not able to locate a physician statement which documented a rationale for the use of two antidepressants. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said he did not know what specific behaviors the resident displayed to justify the use of the olanzapine antipsychotic medication for dementia. Certified nurse aide (CNA) # 2 was interviewed on 4/11/24 at 1:30 p.m. CNA #2 said the resident did not have any aggressive behaviors. He said the resident would occasionally raise his voice when he needed help from staff. He said all of the resident's requests were reasonable and related to care. CNA #2 said the resident did not use the call light but preferred to yell to help when needed. Registered nurse (RN) #3 was interviewed on 4/11/23 at 2:05 p.m. RN #3 said the resident did not have any aggressive behaviors and he did not usually refuse care. She said the resident would occasionally get upset with care provided in the middle of the night. She said the resident used to live in assisted living and he was not accustomed to the call light system. She said the resident did not use the call light and often yelled for help. RN #3 said all the resident's requests were reasonable and pertinent to the care he needed. She said the resident had several hospitalization s during his stay in the facility and every time after his return he was more agitated and would yell for help. Once settled and adjusted to the routine he would not yell as much. RN #3 said if Resident #66 had behaviors they would be documented under progress notes. She said if the behavior was new and acute in onset, the event task would be started and behaviors would be monitored daily. RN #3 said for residents who were started on medications for insomnia, hours of sleep should be documented to ensure the medication was effective. She said Resident #66 was admitted with the medication for insomnia and she was not sure how and when tracking of hours of sleep should have been started. The assistant director of nursing (ADON) was interviewed on 4/11/23 at 2:45 p.m. The ADON said behavior tracking was usually documented under events. He said assessments for side effects of psychotropic medications should be documented under progress notes. He said resident's medication administration records did not include daily behavior tracking.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in one of one kitchen and one of two nourishment rooms. Specifically, the facility failed to: -Ensure holding temperatures were at appropriate temperatures; and, -Ensure food was labeled, dated and disposed of in a timely manner. I. Failure to ensure holding temperatures were at appropriate temperatures. A. Professional reference The Colorado Retail Food Establishment Rules and Regulations, ([DATE]) were retrieved on [DATE] from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view and read in pertinent part, The food shall have an initial temperature of 41 F (fahrenheit) or less when removed from cold holding temperature control or 135 F or greater when removed from hot holding temperature control. B. Observations During a continuous observation of the kitchen on [DATE], beginning at 11:30 a.m. and ending at 12:20 p.m., tartar sauce was observed on a cart next to the oven and stove.The tartar sauce was portioned into two ounce (oz) to four oz sized plastic cups. The cups were on a cookie sheet. There was no mechanism to keep it cold. At 12:20 p.m. cook (CK) #1 took the temperature of the tartar sauce. CK #1 said the tartar sauce contained mayonnaise and lemon juice. -The temperature of the tartar sauce read 62 degrees F, which was above the appropriate cold holding temperature of 41 degrees F. CK #1 spoke to the dietary manager (DM) to confirm she was to discard the tartar sauce. The tartar sauce was discarded in the trash. C. Interviews The registered dietician (RD) was interviewed on [DATE] at 11:52 a.m. The RD said the tartar sauce needed to be discarded if it was not kept at a cold holding temperature of 41 degrees F or below in order to avoid the danger zone for potential food-borne illnesses. The dietary manager (DM) was interviewed on [DATE] at 2:02 p.m. The DM said there should be a cooling mechanism to keep the tartar sauce at the appropriate holding temperature. She said the tartar sauce should remain below 41 degrees F below for cold foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Failure to ensure food was labeled, dated and disposed of in a timely manner A. Professional reference The Colorado Retail Food Establishment Rules and Regulations ([DATE]), retrieved on [DATE] from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, read in pertinent part, A date marking system that meets the criteria stated in one (1) and two (2) of this section may include: Using a method approved by the department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine, marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded, marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this section or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. B. Observations On [DATE] at 9:40 a.m. an observation of the main refrigerator in the kitchen revealed the following:. There was an eight ounce plastic cup covered with aluminum foil in the refrigerator. The foil was labeled with a resident's name and indicated the cup contained a chocolate milkshake. -The foil was labeled with date [DATE] (10 days earlier). -There was an opened almond milk carton without a discard date on it. On [DATE] at 10:34 a.m. observations of the refrigerator in the west unit's nourishment room revealed the following: There was one opened Pedialyte (a liquid product to replace fluids and minerals) plastic carton. The manufacturer label said to discard if not used within 48 hours. -There was no date to indicate when the Pedialyte carton was opened. There was one Magic Cup nutritional supplement in the refrigerator. The manufacturer label said to use it within five days if thawed for pudding-like texture. -There was no date on the Magic Cup to indicate when the supplement was thawed. C. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RD and the nursing home administrator (NHA) were interviewed on [DATE] at 11:52 a.m. The RD said milkshakes that are poured into a plastic cup and covered with aluminum foil expired within the same date the cups were labeled. The NHA said the resident's personal chocolate milkshake, opened almond milk carton, Pedialyte carton and the Magic Cup should have had a used by date on them. The DM was interviewed on [DATE] at 2:02 p.m. The DM said the opened containers should have an opened on and use by date. She said the opened items in the main kitchen refrigerator and the west unit's nourishment room should have had a used by date on them.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review, and interviews, the facility failed to establish a sanitary environment to help prevent the transmission of communicable diseases and infections on three of five units. Specifically, the facility failed to: -Ensure enhanced barrier precautions (EBP) were implemented and followed for residents with wounds and/or indwelling medical devices; and, -Ensure staff used appropriate personal protective equipment (PPE) when entering the room of a COVID-19 positive resident. Findings include: I. PPE failures for EBP A. Facility policy The Infection Prevention and Control Program policy, revised January 2023, was received by the nursing home administrator (NHA) on 4/9/24 at 10:38 a.m. The policy read in pertinent part, Multi-drug resistant organisms (MDRO) are defined as microorganisms that are resistant to one or more cases or antimicrobial agents. Enhanced barrier precautions (EBP) may be indicated for residents with any of the following, as directed by the infection preventionist and/or provider: wounds or indwelling medical devices, regardless of MDRO colonization status or infection or colonization with an MDRO. EBP include the use of gloves and gown during a high-contact care activities such as: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) or wound care for any open skin requiring a dressing. B. Resident #9 observations Resident #9 was observed on 4/8/24 at 2:01 p.m. He was inside the room seated in a wheelchair and had an indwelling catheter bag hanging from his wheelchair. Resident #9 was observed on 4/10/24 at 2:00 p.m. An unidentified certified nursing aide (CNA) and registered nurse (RN) #1 went into the resident's room to transfer the resident from the recliner chair to his bed for a wound dressing change. -The unidentified CNA and RN #1 did not put on gloves or gowns before they initiated the transfer. The wound care registered nurse (WCRN) entered the resident's room once he was in bed. -The WCRN did not put on a gown prior to completing the wound care dressing change for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #30 observations Resident #30 was observed on 4/8/24 at 1:49 p.m. Resident #30 was seated in a wheelchair in her room. An unidentified CNA went into her room to provide care. -The CNA did not put on a gown or gloves while transferring the resident from her wheelchair to the recliner chair. Resident #30 was observed on 4/9/24 at 3:56 p.m. RN #1 went into the resident's room to look at her pressure ulcers on both heels. She peeled back the resident's wound dressings to look at the wounds and put the dressings back into place. -RN #1 did not put on a gown while completing the resident's wound care. D. Staff interviews The infection preventionist (IP) and corporate nurse consultant (CNC) #1 were interviewed on 4/11/24 at 10:40 a.m. The IP said the facility currently did not have EBP in place for residents without MDROs who had indwelling medical devices or wounds. She said placing residents on EBP had not been done yet due to the lengthy process that was involved. She said the process involved educating residents, resident representatives and staff on the procedure. The IP said the facility had adequate PPE, such as gloves, gowns, eye protection, and masks in order to place all residents with indwelling devices/wounds on EBP. CNC #1 said they were aware of new requirements for EBP and were planning to implement it next week (week of 4/15/24). 37166 II. PPE Failures for COVID-19 positive room A. Professional reference According to the Center for Disease Control and Prevention (CDC) Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 (6/3/2020), retrieved on 4/17/24 from https://www.cdc. gov/coronavirus/2019-ncov/downloads/communication/print-resources/A_FS_HCP_COVID19_PPE_card.pdf, PPE must be donned correctly before entering the patient area (for example, isolation room, unit if cohorting). PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (for example, retying gown, adjusting respirator/face mask) during patient care. PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care. B. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 12:11 p.m. CNA #4 was observed delivering a lunch tray to room [ROOM NUMBER]. The sign on the door indicated staff were to wear PPE, including a gown, gloves, N95 mask and face shield. CNA #4 donned a yellow gown, placed a N95 mask on top of the surgical mask he was wearing, put on a face shield and gloves and entered the room. CNA #4 exited the room at 12:15 p.m. wearing a surgical mask. On 4/10/24 at 12:22 p.m. CNA #3 entered room [ROOM NUMBER]. -CNA #3 donned a gown, face shield and gloves prior to entering the resident's room, however, he failed to remove his surgical mask and put on a N95 mask. CNA #3 entered the room wearing a surgical mask. C. Staff interviews CNA #3 was interviewed on 4/10/24 at 12:39 p.m. CNA #3 said he should have been wearing a N95 mask but he forgot. The infection preventionist (IP) was interviewed on 4/10/24 at 1:20 p.m. The IP said the resident in room [ROOM NUMBER] tested positive for COVID-19. She said appropriate PPE for the room was a N95 mask, gown, gloves and face shield. The IP said a N95 mask should not be worn on top of a surgical mask. She said having a surgical mask under a N95 mask compromised the seal of the N95 mask and did not provide adequate protection.